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) 42500 (Completion Date 06/11/2024) and 38786 (Completion Date 04/03/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/11/2024 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-2630, WAC 388-78A-2630-1, WAC 388-78A-2630-1-a

The Department staff who did the on-site verification:
Paul Aube, ALF NCI

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 #: 38786
Intake ID: 122804
Investigator: Paul Aube
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 03/25/2024 through 04/03/2024
Complainant Contact Date(s):

Allegation(s):

Quality of Care/Treatment: Public report of staff person sleeping while on-duty leaving residents unmonitored, and staff not answering call lights when summoned.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 2 Closed records sample size: 1
Observations:	Residents Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members Management
Record Reviews:	Facility policies Incident Log Incident Report Progress Notes Personnel files Staff Schedules

Investigation Summary:

Quality of Care/Treatment: Facility made aware of allegation of neglect for staff persons sleeping while on duty, and leaving residents unmonitored. Allegations were substantiated and corrective actions issued. No notification made to the Department after allegations of neglect received. Failed practice identified.

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 # 38786
Plan of Correction	The Cottages at Lacey	Completion Date
Page 1 of 4	Licensee: Lacey Special Care Community LLC	04/03/2024

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 complaint investigation on 03/25/2024 and 04/03/2024 of:

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

This document references the following complaint number(s): 122804, 123264, 123242

The following sample was selected for review during the unannounced on-site visit: 2 of 51 current residents and 1 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

04/03/2024
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.

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Statement of Deficiencies	License #: 2443	Compliance Determination # 38786
Plan of Correction	The Cottages at Lacey	Completion Date
Page 2 of 4	Licensee: Lacey Special Care Community LLC	04/03/2024

Administrator (or Representative)

4/3/24
Date

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 interview and record review, the memory care facility failed to notify the Department's Complaint Resolution Unit after they became aware of an allegation of neglect for 1 of 1 staff person reviewed, (Staff C). This failure resulted in the Department being unable to investigate the allegation, which placed all residents who reside at the facility at risk for ongoing neglect.

Findings included...

"WAC 388-78A-2020, Definitions. 'Neglect' means: (1) A pattern of conduct or inaction resulting in the failure to provide the goods and services that maintain physical or mental health of a resident, or that fails to avoid or prevent physical or mental harm or pain to a resident; or (2) An act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the resident's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100."

Review of the facility policy, titled, "Abuse-Neglect-Exploitation," dated 09/28/2020, under the section titled, "Reporting/Notifications: Staff Responsibilities", it stated, "It is the responsibility of each staff member to immediately contact the Department Hotline directly regarding suspected or alleged abuse, neglect, or exploitation...Any staff member to witness, receive report, suspect, or become aware of abuse, neglect, or exploitation, sexual, or physical assault of a resident is responsible for notifying the 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 the shift."

During an interview on 03/28/2024 at 1:55PM, Collateral Contact (CC1), Resident 1's (R1) family member, stated that they were staying at the facility with R1 overnight due to R1 being in the process of passing away. CC1 stated that Hospice (a program that gives special care to people who are near the end of life) educated them on signs to look for that could indicate that R1 was experiencing pain, such as wincing, etc. CC1 stated that during

Administrator (or Representative) Date

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the night before they were about to go to sleep, they noticed R1 to appear to be in pain. CC1 exited R1's room to look for Staff C, the Medication Technician, to ask them to administer pain medication, and found Staff C sleeping in the common area/resident living room. CC1 stated that Staff C was observed to be sleeping in a recliner, reclined or leaned back with their feet up on the footrest, and a hat partially covering their eyes. CC1 stated that they called out to Staff C three times and got no response. "I tapped [Staff C] on the arm and called [their] name. I tapped [them] three times and [Staff C] did not answer me. I then shook [them] and asked if [they] [were] awake and told [them] it was time for [R1's] medication. [Staff C] eventually got up and you could tell [they] [were] in that stupor like [they] had just woken up, and [they] went to the medication cart and started getting the medication ready. This also worried me that [they] were going to give [R1] the wrong dose." CC1 was asked if there were any other staff in the building that could have assisted, or if all residents were left unmonitored while Staff C was asleep. CC1 stated that Staff C was the only person in the building at that time, and that the other on-shift staff were in another building. CC1 was asked if these concerns of Staff C sleeping while on-duty were brought to management's attention. CC1 stated, "We went to [Staff A, the Executive Director], and [Staff B, the Director of Nursing] and let them know the next day." CC1 was asked what Staff A and Staff B's response was after being notified about Staff C sleeping while on-duty. CC1 stated, "They told me that was grounds for dismissal and that [Staff C] would be fired." CC1 stated that they knew for a fact that Staff C was not fired because they saw that Staff C was working on another night.

During an interview on 03/25/2024 at 12:31PM, Staff A was asked if they were made aware of any staff persons sleeping while on-duty. Staff A stated that while meeting with CC1, "[CC1] brought up those complaints as well." Staff A provided an undated, and untimed handwritten note, taken from their meeting with CC1 for Department review. Review of the notes from the meeting stated "[Staff C] asleep 2x." On the second page it stated, "[Staff C] was sleeping on the job." Staff A was asked if they investigated this allegation further, and if they determined them to be substantiated. Staff A stated that they provided Staff C with a final written warning for the complaint of them sleeping while on duty.

Review of a Corrective Action for Staff C, dated 03/15/2024, stated, "It was brought to our attention you were sleeping at work. This is unacceptable and you must be awake for every shift." Under "Action being taken," "Final Warning" was marked with an "X."

Review of Department records on 03/25/2024 showed no notification/reports submitted by the facility of an allegation of neglect from Staff C.

During an interview on 03/25/2024 at 1:13PM, Staff B was asked the timeframe in which allegations of neglect should be reported to state. Staff B stated, "Immediately." Staff B was then asked why the allegation of Staff C sleeping while on-duty was not reported to the Department. Staff B stated, "I don't know."

During an interview on 03/25/2024 at 12:52PM, Staff A was asked how they would define neglect. Staff A stated, "Neglect is defined as improper care or failure to care for resident." Staff A was asked if they thought a staff person sleeping while on duty is considered

the night before they were about to go to sleep, they noticed R1 to appear to be in pain. CC1 exited R1's room to look for Staff C, the Medication Technician, to ask them to administer pain medication, and found Staff C sleeping in the common area/resident living room. CC1 stated that Staff C was observed to be sleeping in a recliner, reclined or leaned back with their feet up on the footrest, and a hat partially covering their eyes. CC1 stated that they called out to Staff C three times and got no response. "I tapped [Staff C] on the arm and called [their] name. I tapped [them] three times and [Staff C] did not answer me. I then shook [them] and asked if [they] [were] awake and told [them] it was time for [R1's] medication. [Staff C] eventually got up and you could tell [they] [were] in that stupor like [they] had just woken up, and [they] went to the medication cart and started getting the medication ready. This also worried me that [they] were going to give [R1] the wrong dose." CC1 was asked if there were any other staff in the building that could have assisted, or if all residents were left unmonitored while Staff C was asleep. CC1 stated that Staff C was the only person in the building at that time, and that the other on-shift staff were in another building. CC1 was asked if these concerns of Staff C sleeping while on-duty were brought to management's attention. CC1 stated, "We went to [Staff A, the Executive Director], and [Staff B, the Director of Nursing] and let them know the next day." CC1 was asked what Staff A and Staff B's response was after being notified about Staff C sleeping while on-duty. CC1 stated, "They told me that was grounds for dismissal and that [Staff C] would be fired." CC1 stated that they knew for a fact that Staff C was not fired because they saw that Staff C was working on another night.

During an interview on 03/25/2024 at 12:31PM, Staff A was asked if they were made aware of any staff persons sleeping while on-duty. Staff A stated that while meeting with CC1, "[CC1] brought up those complaints as well." Staff A provided an undated, and untimed handwritten note, taken from their meeting with CC1 for Department review. Review of the notes from the meeting stated "[Staff C] asleep 2x." On the second page it stated, "[Staff C] was sleeping on the job." Staff A was asked if they investigated this allegation further, and if they determined them to be substantiated. Staff A stated that they provided Staff C with a final written warning for the complaint of them sleeping while on duty.

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During an interview on 03/25/2024 at 1:13PM, Staff B was asked the timeframe in which allegations of neglect should be reported to state. Staff B stated, "Immediately." Staff B was then asked why the allegation of Staff C sleeping while on-duty was not reported to the Department. Staff B stated, "I don't know."

During an interview on 03/25/2024 at 12:52PM, Staff A was asked how they would define neglect. Staff A stated, "Neglect is defined as improper care or failure to care for resident." Staff A was asked if they thought a staff person sleeping while on duty is considered

'falling to care for a resident.' Staff A stated, "If they are sleeping, they can't care for the resident." Staff A was then asked why the Department was not notified when they became aware of the allegation of neglect from Staff C. Staff A shook their head and did not respond. Staff A was asked if that action meant they did not know. Staff A again shook their head.

This is a recurring deficiency previously cited on 05/03/2023.

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) 5/18/24 .

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

Administrator (or Representative) — Date: 4/5/24

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