STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

10/20/2025

Lacey Special Care Community LLC
The Cottages at Lacey
8570 Martin Way E
Lacey, WA 98516

RE: The Cottages at Lacey # 2443

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 67421 (Completion Date 10/20/2025) and 63859 (Completion Date 08/22/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/20/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(7) Not allow any staff person to abuse or neglect any resident.

The Department staff who did the On Site verification:
Anissa Bearden, Licensor

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley, Adult Family Home Nurse 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 #: 63859
Intake ID: 190100
Investigator: Anissa Bearden
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 08/08/2025 through 08/22/2025
Complainant Contact Date(s):

Allegation(s):
Allegation of refusing the residents right to have free will and access to their room.

Investigation Methods:

Sample:
Total residents: 57
Resident sample size: 4
Closed records sample size: 0

Observations:
Residents
Identified resident
Resident rooms
Staff to resident interactions

Interviews:
Identified resident
Identified staff
Nursing staff
Residents
Administrative staff

Record Reviews:
Medical records
State reporting log
Incident investigation
Facility policies
Personnel files

Investigation Summary:
After observation, interview, and record review, two caregivers refused to allow a resident to enter their room when they desired and locked the door to prevent the resident from entering. This was failed practice against resident rights.

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 # 63859
Plan of Correction	The Cottages at Lacey	Completion Date
Page 1 of 4	Licensee: Lacey Special Care Community LLC	08/22/2025

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 08/08/2025 of:

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

This document references the following complaint number(s): 188341, 190100, 190259

The following sample was selected for review during the unannounced on-site visit: 4 of 57 current residents and 0 former residents.

The department staff that investigated 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.

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) | Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(7) Not allow any staff person to abuse or neglect any resident.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure staff promoted care for residents in a manner that maintained or enhanced the residents dignity and respect for 1 of 1 residents (Resident 4 [R4]) when R4 was not allowed to have free access to their own apartment. This failure resulted in R4’s being kept from accessing their room when they wanted and contributed to R4 exhibiting signs of distress and anxiety and having a decreased quality of life.

Findings included…

Revised Code of Washington (RCW) 70.129.020 “Exercise of rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident and assist the resident which include: (2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.”

RCW 70.129.140 (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Record review of the facility's policy "Resident Rights," undated, showed it was the policy for the facility to uphold and protect the rights of residents.

Record review of R4's move in record, dated 08/08/2025, showed R4 moved into the facility on /2024 with multiple medical diagnoses that included and .

Record review of R4's Service Plan Report, undated, showed R4 was independent with all ambulation and transfers without the use of assistive devices or staff assistance. R4 had a history of resisting care. Staff were to respect R4's choice to decline assistance.

In an unannounced inspection on 08/08/2025 at 1:25 PM, inside the facility's Cottage D, Staff B, Caregiver, Staff C, Caregiver, and R4 were observed coming out of R4's bedroom, Staff B was standing between R4 and the bedroom door while Staff C stood beside Staff B. Staff B then pulled out keys from their pocket and locked R4's door while R4 was raising their hands and arms up and down multiple times, jumping, and shouting "no, no," with a raised voice. Staff B continued to lock the door despite R4's reaction and Staff B and Staff C looked at each other, smiled, and began to laugh. Staff B and Staff C then walked away from R4. R4 was observed trying to open their bedroom door with the handle, the door did not open as it was locked, and continued to bang on the bedroom door saying, "no" and shouting. Staff B continued to walk away when they observed the licensor observing R4, Staff B then stopped, walked back to R4's bedroom door and unlocked the door, R4 stopped shouting and hitting the bedroom door, and stopped raising their arms up and down and entered their bedroom and shut the door.

On 08/08/2025 at 1:27 PM, Staff B stated R4 was allowed to go into their room if they wanted and that R4 was putting three to four layers of clothing on which was why Staff B had locked R4's bedroom door. Staff B stated if R4 soiled their pants or other clothing, they would just put more clothing on. Staff B acknowledged that R4 had the right to enter their room anytime they desired.

On 08/08/2025 at 1:27 PM, Staff C acknowledged that it was R4's right to put as many layers of clothing on as they desired.

In an interview on 08/08/2025 at 1:41 PM, Staff F, Caregiver, stated R4 did prefer to be in their room most of the time and that they have a history of making messes in their

room, but they would just try and redirect them. Staff F stated they were not to lock any residents out of their room and only locked a resident's room if they requested the door to be locked.

In an interview on 08/08/2025 at 1:47 PM, Staff D, Medication Technician, stated R4 was allowed to go into their room anytime they desired. Staff D stated it was not the facility's common practice to lock the residents' rooms to keep them out of there.

In an interview on 08/08/2025 at 2:06 PM, Staff E, Director of Nursing, stated it was not common for R4 to have their door locked or staff to lock R4's door.

In an interview on 08/08/2025 at 2:35 PM, Staff A, Executive Director, acknowledged that Staff B and Staff C were not to lock R4's bedroom door to keep R4 out of their room.

This is a recurring deficiency previously cited on 08/10/2022.

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