STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 72029 (Completion Date 01/26/2026) and 63541 (Completion Date 10/27/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/26/2026 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-2240

The Department staff who did the on-site verification:
Pamela Horlick, NCI RN Complaint Investigator
Clinton Fridley, Community Nurse Field Manager

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

Sincerely,

Clinton Fridley RN

Clinton Fridley, Community 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 #: 63541
Intake ID: 187652
Investigator: Pamela Horlick
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 08/04/2025 through 10/27/2025
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Report of facility failing to obtain a residents prescribed medication.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 4 Closed records sample size: 3
Observations:	Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Nursing staff Family members Nurse at hospital
Record Reviews:	Medical records Hospital records State reporting log Facility policies Medication Administration Record Physician Orders Progress Notes

Investigation Summary:
Quality of Care/Treatment: Facility failed to obtain medications for a resident after they were prescribed. Failed practice identified.

Conclusion / Action:

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

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

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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 08/04/2025 of:

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

This document references the following complaint number(s): 187652

The following sample was selected for review during the unannounced on-site visit: 4 of 56 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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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.

Clinton Fridley RN
Residential Care Services

11/04/2025
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)

11/5/25
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility (ALF) failed to ensure medications were obtained from the pharmacy after a physician ordered them to treat an infection for 1 of 3 residents (Resident 1). This failure resulted in the facility failing to acquire the medication and Resident 1 (R1) not being treated in the facility for the infection which led to a worsening in the resident's condition requiring hospitalization.

Findings included...

Record review of facility policy titled, "Medication Unavailable," revised on 06/22/2021, showed that the assisted living facility (ALF) was to order/reorder medications for residents that are receiving mediation services in a timeframe and manner that promotes health and if medications were unavailable, facility staff would attempt to determine the cause for unavailability and take steps in attempt to obtain needed medications, including repeated contact with physician/pharmacy and all efforts would be documented in the resident record and the resident/responsible party and resident physician would be notified.

Record review of facility records showed that R1 was admitted on [redacted]/2025 with various diagnoses including [redacted] and [redacted].

Record review of facility resident records titled, "Service Plan Report," dated [redacted]/2025, showed that facility staff were to order and maintain all medications and assist resident medications as per physician order and that staff are to order all medicine and ensure R1 is receiving the right medication at the right dosage and to notify director of nursing services (DNS) and primary care physician (PCP) if R1 is refusing medications.

Review of R1's progress notes, dated 07/15/2025, documented that R1 was experiencing a change of condition, behavior changes, speech was difficult to understand, refusing to eat/drink and had difficulty taking medications.

Review of R1's progress notes, dated 07/16/2025, documented that a medical provider came in to assess R1 in the morning and R1 refused to eat or drink.

Record review of DispatchHealth (a mobile healthcare provider) documentation, dated 07/16/2025, documented that R1 was seen by a physician's assistant (PA) on 07/16/2025 at 08:29 AM. The reason for the visit was UTI, cloudy urine, lethargy, and anxiety. R1 had resided at the facility for a week and started having worsening symptoms yesterday, consistent with previous UTI's they have had. Otherwise, R1 was healthy. The diagnosis was [redacted] and documented that urosepsis was unlikely given non-toxic appearance with stable vital signs. Cefdinir (an antibiotic drug used to treat bacterial infections) 300 milligrams (mg) capsules were ordered on 07/16/2025 to be taken every 12 hours for seven days for UTI. Staff were to push fluids and follow-up as needed if symptoms worsen or fail to improve.

Record review of the prescription sent to R1's pharmacy, written on 07/16/2025, showed an order for Cefdinir 300 mg capsule to be given once every 12 hours for seven days for UTI and was received by R1's pharmacy on 07/16/2025. R1's birthdate on the prescription order did not match the correct birthdate for R1.

Record review of a pharmacy document titled, "Permission to Bill Facility for Non-Covered Medications," dated 07/17/2025, showed a fax was sent to the facility to request the facility be billed for the antibiotic. A second attempt to request the facility be billed for the antibiotic was made by the pharmacy on 07/18/2025. Listed on the fax was R1's name, correct date of birth and the antibiotic order details.

Review of R1's Medication Administration Record (MAR), from 07/16/2025 through [redacted]/2028, showed an order for Cefdinir 300 mg with directions to take one capsule by mouth every 12 hours for seven days for UTI. Further review of R1's MAR showed the order for Cefdinir was labeled as pending confirmation, with a start date of 07/16/2025 at 1:51 PM and no documentation on the MAR indicating the medication was administered.

Review of R1's progress note, dated 07/17/2025, documented that R1 stayed in bed all shift and did not eat breakfast or lunch. The pharmacy was contacted regarding the antibiotic (cefdinir) and stated they did not receive the paperwork and that Staff B, Director of Nursing (DON), was notified. Staff C, Resident Care Coordinator (RCC) reached out to the pharmacy and discovered that the pharmacy had the wrong birth date documented for R1 and then the pharmacy staff stated that they didn't know why the antibiotic wasn't sent but that they will send it tonight.

Review of email communication, dated 07/18/2025, documented that Staff C, Resident Care Coordinator (RCC), responded to a pharmacy email providing additional information as requested.

Review of R1's progress notes, dated 07/18/2025, documented that R1 was combative with staff during care and did not eat breakfast or lunch and refused to leave their room.

Review of R1's progress notes, dated 07/19/2025, documented that R1 seemed weak and couldn't communicate thoroughly.

Review of R1's progress notes, dated 07/20/2025, documented that R1 was "on a steep decline" and that they are very drowsy and sleepy and not eating.

Review of R1's progress notes, dated [redacted]/2025, documented that R1's primary care physician (PCP) was at the ALF to establish care and R1 was diagnosed with a [redacted] and had not received antibiotics from the pharmacy despite speaking with the pharmacy on 07/17/2025 and being told it would be sent out, medication did not arrive at the facility and R1 was transported to the hospital.

Record review of R1's facility records, on 08/04/2025, showed no documentation that R1's family or PCP was notified of missed medication or issues surrounding obtaining the medication, nor did it show further attempts documented that the ALF reached out to the pharmacy after 07/18/2025.

On 08/04/2025 at 3:11 PM, Staff A, Executive Director. stated that R1s PCP could have been notified when R1 hadn't received the antibiotic that was ordered. Staff A stated that it was not appropriate for a resident to go five to six days without medications after it was ordered and stated that R1's UTI treatment, due to the ALF not receiving the antibiotic, had been delayed. Staff A was unsure if R1's resident representative was ever notified of the delay in antibiotic treatment and stated that generally, it was facility practice to notify the family.

On 08/05/2025 at 1:14 PM, Collateral Contact 1 (CC1) stated that on 07/15/2025 they were visiting R1 and had concerns about his behavior and noticed R1's urine was

cloudy. CC1 informed facility staff of their concerns and believed that R1 had a UTI. CC1 stated on 07/16/2025, the ALF called DispatchHealth to assess R1 and that CC1 was notified by Staff A, on 07/16/2025, that R1 had a UTI and was started on antibiotics.

On 08/05/2025 at 1:14 PM, CC1 stated that on [redacted]/2025 they received a call from the ALF that R1 was being transported to the hospital and that they were never informed that R1 had not received the antibiotics ordered to treat the UTI and that the CC1 was notified of that fact by the emergency medical transport (EMT) personnel. CC1 stated that if they had known about R1's issue with getting the antibiotics from the pharmacy, they would have taken care of it immediately and found a way to obtain the medication and mentioned that the ALF never communicated about the missing antibiotics with them.

Record review of R1's hospital documentation titled, "Admission Note," dated [redacted]/2025, documented "Upon examination, patient appears to have intermittent agonal [abnormal pattern of breathing characterized by gasping or labored breathing] breathing. Patient appears cachectic [sever muscle and weight loss] and visibly has bacteria growing along his lips, back of his mouth, teeth and tongue." Also documented "we [hospital] are admitting for continued comfort cares."

Record review of R1's hospital documentation titled, "Discharge Summary Note," dated [redacted]/2025 at 7:48 AM, documented R1 was admitted on [redacted]/2025, with an admitting diagnoses of [redacted], discharged due to R1's passing away on [redacted]/2025 at 9:14 PM, documented immediate cause of death was "probable severe sepsis [a life-threatening condition that occurs when the body's immune system overreacts to an infection] secondary to urinary tract infection" and other significant factors contributing to death was documented as "acute metabolic encephalopathy [condition where the brains function is impaired due to a systemic metabolic or toxic disturbance] superimposed [on top of] on underlying severe dementia."

On 09/02/2025 at 12:29 PM, Staff B, Director of Nursing, stated that if medications aren't received from the pharmacy, management staff (Staff A, Staff B, and Staff C) call the pharmacy to find out why the medication wasn't sent, if this doesn't work, they email the pharmacy account manager. If a medication/pharmacy issue arises over the weekend, Staff C, Resident Care Coordinator, follows up with the pharmacy. Staff B stated when a medication doesn't arrive, they will notify the PCP.

On 09/03/2025 at 3:59 PM, Staff D, Medication Technician, stated they worked on 07/19/2025. Staff D stated if a medication that was ordered during the week had not come in by the weekend, they would contact Staff C and Staff C would notify Staff B. Staff D was asked if they remember contacting the pharmacy on 07/19/2025 when R1's antibiotic was unavailable, they stated they don't recall.

On 09/18/2025 at 9:27 AM, Collateral Contact 2 (CC2), pharmacy staff, stated the medication was never filled due to insurance. CC2 stated the pharmacy faxed the

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facility on 07/17/2025 and again on 07/18/2025 to get approval to bill the facility for the antibiotic. CC2 stated they never received a response back from the facility regarding the faxes.

In an interview on 10/27/2025 at 3:28 PM, Staff C, Resident Care Coordinator, stated they didn't remember reaching back out to the pharmacy on 07/18/2025 to follow up after emailing the pharmacy about R1's medication and did not work the weekend following 07/18/2025. Staff C stated they didn't get a call from the medication technicians that weekend when the medication had not arrived and didn't remember if they received two faxes from the pharmacy asking the facility to pay for the medication.

This is a recurring deficiency previously cited on 10/14/2024.

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) 12/11/25 .

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

Administrator (or Representative) 11/5/25 Date