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

11/07/2024

Greenlake Management Lacey, LLC
Memory Care At The Lodges
1530 Carpenter Rd SE
Lacey, WA 98503

RE: Memory Care At The Lodges # 2600

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 49639 (Completion Date 11/07/2024) and 40928 (Completion Date 05/08/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/07/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

The Department staff who did the On Site verification:
Phan Pham, Nurse Surveyor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Memory Care At The Lodges **Provider Type:** Assisted Living Facility

License/Cert.#: 2600
Intake ID: 129622
Compliance Determination #: 40928
Region/Unit #: RCS Region 3 / Unit E
Investigator: Phan Pham
Investigation Date(s): 05/07/2024 through 05/08/2024
Complainant Contact Date(s): 05/07/2024

Allegation(s):
Physical environment - The assisted living sewer was backed up and rooms were flooded.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 3 Closed records sample size: 0
Observations:	Named resident, residents, environment, staff interactions with residents, staff members providing care and services, and safety measures.
Interviews:	Named resident, residents, staff members, administrative and member not associated with the facility.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:
An on-site investigation was conducted, and the concerns related to physical environment, quality of care and treatments were reviewed. The Assisted Living Facility had a sewage blockage and was backed up and failed to ensure staff members reported the incident to the Complaint Resolution Unit hotline in a timely manner.

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 # 2600	Compliance Determination # 40928
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 1 of 3	Licensee: Greenlake Management Lacey, LLC	05/08/2024

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 05/07/2024, 05/07/2024 and 05/10/2024 of:

Memory Care At The Lodges
1530 Carpenter Rd SE
Lacey, WA 98503

This document references the following complaint number(s): 129622

The following sample was selected for review during the unannounced on-site visit: 3 of 51 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Nurse Surveyor

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

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

Cory Cisneros
Residential Care Services

05/13/2024
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.

Administrator (or Representative) 5/30/24 Date

WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

This requirement was not met as evidenced by:

Based on observation, and interview, the Assisted Living Facility had a sewage blockage and was backed up and failed to ensure staff members reported the incident to the Complaint Resolution Unit (CRU) hotline in a timely manner for 1 of 1 facility reviewed. This failure placed residents at risk of not receiving the necessary care and services, and decreased quality of life.

Findings included...

In an observation on 05/07/2024 at 10:49 AM, the assisted living facility showed there were 16 rooms and 24 residents resided in "Lodge 2." Each of the resident's room was equipped with a walk-in shower, a toilet and a sink. The bathrooms floor was covered with vinyl and the rest of the residents' rooms were carpeted and the carpet extended to the hallway.

In an interview and observation on 05/07/2024 at 11:04 AM, Resident 2 was observed in her wheelchair in her room. Resident 2's room was observed to be cleaned and dried. Resident 2 said her toilet was backed up the day before and staff fixed it.

In an observation and interview on 05/07/2024 at 11:15 AM, Resident 1 was observed in his bed and covered with blankets. Resident 1's room was observed, and it was clean and dry. Resident 1 said on the morning of 05/06/2024 his toilet was overflown and the carpet in his room was wet.

In an interview on 05/07/2024 at 11:35 AM, Staff C, Caregiver, said on 05/06/2024 she came on shift and the front hallway of the assisted living facility was flooded. Staff C stated all the residents' rooms had standing sewage in their showers and the toilets were overflown. Staff C stated some of the resident's rooms had approximately one inch of sewage mixed with feces, dark colored water and food in their bathrooms and showers. Staff C said Resident 2's rooms had water all over his room, the carpet in the resident's room was wet, the water got to the hallway and to the connecting room. Staff C stated Resident 1's room had water in the living area, closet and out to hallway.

In an interview on 05/07/2024 at 12:21 PM, Staff D, Caregiver, stated on 05/06/2024 she came on shift at approximately 7:00 AM and all the residents' rooms were flooded. Staff D said she observed standing "poop" water in every shower, bathrooms floor and some were on the carpet in residents' rooms and hallways. Staff D stated staff none of the residents got showered from 7:00 AM to 3:00 PM on 05/06/2024.

In an interview on 05/07/2024 at 12:32 PM, Staff B, Medication Technician, said she came on shift at 7:00 AM on 06/24/2024 and saw all the rooms by the front hallway had standing sewer water in the showers, bathrooms and the carpet in the residents' room and hallway was wet. Staff B stated staff were not able to flush and no resident got showered. Staff B said she had been trained to report abuse and neglect to the state.

In an interview on 05/07/2024 at 10:32 AM, Staff A, Executive Director, said the Assisted Living Facility's sewer mainline had a blockage on 05/06/2024 and some of the residents' rooms were affected. Staff A stated Resident 1 and Resident 2's rooms were most affected, and the water got to the carpet. Staff A said maintenance staff cleared the line and extracted the water. Staff A stated her priority was to ensure residents' rooms were cleaned, water extracted and did not make the report to CRU.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 5/30/24.

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

Yvonne M Kinch — Administrator (or Representative)

5/30/24 — Date