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

07/11/2025

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) 62433 (Completion Date 07/11/2025) and 58171 (Completion Date 05/14/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/11/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

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

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

The Department staff who did the On Site verification:
Pamela Horlick, NCI RN Complaint Investigator

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

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse 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

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 04/16/2025 of:

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

This document references the following SOD dated: 05/14/2025

The following sample was selected for review during the unannounced on-site visit: 3 of 42 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator
Cory Cisneros, Field Manager

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

Statement of Deficiencies	License #: 2600	Compliance Determination #:58171
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 2 of 8	Licensee: Greenlake Management Lacey, LLC	05/14/2025

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

05/21/2025
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.

Director of Operations
Patricia Santos-Love
Administrator (or Representative)

May 22, 2025
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

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to immediately report an elopement and an incident of potential sexual abuse to the department's Complaint Resolution Unit (CRU) for 2 of 4 incidents reviewed. This failure placed 42 of 42 residents at risk for unreported harm and unmet care needs.

Findings included...

"RCW 74.34.035 Reports—Mandated and Permissive—Contents—Confidentiality. (1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department."

Record review of Assisted Living Facility Guidebook, dated February 2018, showed to report to the department when there was reasonable cause to believe violations had occurred involving abuse, neglect, abandonment, significant injuries of unknown source,

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-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

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to immediately report an elopement and an incident of potential sexual abuse to the department’s Complaint Resolution Unit (CRU) for 2 of 4 incidents reviewed. This failure placed 42 of 42 residents at risk for unreported harm and unmet care needs.

Findings included…

“RCW 74.34.035 Reports—Mandated and Permissive—Contents—Confidentiality. (1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department."

Record review of Assisted Living Facility Guidebook, dated February 2018, showed to report to the department when there was reasonable cause to believe violations had occurred involving abuse, neglect, abandonment, significant injuries of unknown source,

or personal and/or financial exploitation. The guidebook showed for missing residents it should be reported to the department CRU hotline depending on the circumstances of each individual event/incident, the facility may be required to report any alleged, suspected or actual neglect of a resident.

Record review of facility policy, titled, “Abuse and Neglect-Resident,” dated 02/15/2024, stated, “This Community will make every reasonable effort to ensure the safety and wellbeing of our residents and staff and promote a healthy atmosphere free of abuse, neglect, or exploitation. The community will not hire or continue to employ persons with a history of or propensity for abuse in accordance with Guidelines found in the DSHS Assisted Living Guidebook: Partners in Protection. Based on RCW 70.129 Resident Rights, WAC 388-78A-2660, WAC 388-78A-2630…All staff members and residents will be educated about abuse and neglect in the assisted living setting, including definitions, prevention, awareness, investigation and reporting…All allegations of abuse or neglect will be treated as serious and will be investigated, documented and reported per the standards set forth in this policy and procedure…Failure to follow the policy and procedure as set forth will be considered a serious violation of employee responsibilities and will result in disciplinary action up to and including discharge.” Under section “Definitions,” it stated, “Neglect: for the purpose of this policy, Neglect means the active or passive failure to provide the basic care or services necessary to maintain the health and safety of an adult, when that failure results in physical harm, significant emotional harm, unreasonable discomfort, or serious loss of personal dignity to the adult; or creates the risk of serious harm to the adult. The expectation for care may exist because of an assumed responsibility or a legal contractual agreement, including, but no limited to, where an individual has a fiduciary responsibility to assure the continuation of necessary care or services. An adult, who in good faith, is voluntarily under treatment solely by spiritual means in accordance with the tenets and practices of a recognized church or religious denomination shall, for this reason alone, not be considered subjected to abuse by reason of neglect as defined in these rules.” Under the section, titled, ”C. Reporting Witnessed or Suspected Abuse or Neglect,” stated, “ The alleged abuse will be immediately reported by the person who witnessed it, to the supervisor on duty, or the Administrator, and to the appropriate state agency, following the guidelines for mandatory reporting…An incident report will be completed, and the state mandated reporting will be completed and submitted in accordance with state regulations.”

Record review of the “Department of Social And Health Services” document, Completion date 08/05/2024, 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 (Washington Administrative Code) 388-78A-2630] 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, Administrator, signed the document on 08/27/2024. 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 09/19/2024.”

Record review of the facility’s Elopement/Missing Resident Policy, dated 02/15/2024,

showed the facility was to report the elopement to DSHS (Department of Social and Health Services) CRU.

Record review of a progress note for Resident 1 (R1), dated 10/05/2024 at 2:33PM, showed R1 was found outside of lodge 2 at 1:57PM when staff reported that someone jumped out of the window. The screen to a window was removed and the window was open. R1 refused to return to the building and ran down the street to the side building of the main office. Five staff members attempted to get the resident to return to the facility. R1 resisted staff and stated they hated it at the facility and was not the place for him. The administrator was immediately notified of the incident.

Record review of a progress note for R1, dated 10/18/2024, showed staff reported that R1 had another female resident with him in bed and that R1 had their pants down. The female residents brief was partially removed. The female resident presented in a dazed and confused condition at the time she was found. R1 stated he had permission from the family and that the female resident was his fiancé (she was not his fiancé). The female resident was removed from the situation and placed in a different room away from R1. Both residents were placed on monitoring with 15 minute checks being conducted. The administrator was notified of the incident.

Record review of an incident report for R1, dated 10/05/2025, showed R1 required redirection with exit seeking. Abuse and neglect was ruled out. The incident report showed it was circled that the incident did not need to be reported to CRU. The description of the event showed a caregiver was on lunch when they saw two caregivers running. R1 was running and being combative in the parking lot. R1 was yelling and being uncooperative with staff. One caregiver stated the resident had jumped out of a window. R1 fell into a ditch. The notification section as to who was contacted or notified of the incident was blank. The incident report was signed by Staff B, Health and Wellness Director/Nurse.

Record review of the incident log and incident reports, dated 09/20/2024-03/21/2025, showed there was no incident report for the incident on 10/18/2024 for R1.

Review of department records on 04/16/2025 showed the incident on 10/05/2024 and 10/18/2024 for R1 had not been reported to CRU.

In an interview on 04/16/2025 at 1:38PM, Staff B, and Staff A confirmed no incident report was completed for the incident with R1 on 10/18/2024. When asked how R1 eloped out the window and the incident occurred, Staff B stated they didn’t know. When asked if the elopement should have been reported to CRU, Staff A and B confirmed it should have been reported and wasn’t. When asked if the event on 10/18/2024 should have been reported to CRU, Staff B stated he didn’t think so as he did not think the event was sexual abuse because the families didn’t have a problem with it. Documentation was requested showing the family approved of the residents having intimate relations, and Staff B stated they didn’t know if they had documentation. Staff B was asked if they had permission for the resident to have intimate relationships why

did they move the female resident away from R1 and monitor them closely as they did. Staff B stated the event occurred at night and they obtained permission after the fact. Staff B was asked if there was any documentation of these conversations with the family and Staff B confirmed there was no documentation of conversation with the families.

In an interview on 04/16/2025 at 3:41PM, Staff A was asked how they ruled out abuse and neglect for the elopement incident for R1 on 10/05/2024, and they stated staff were with the resident the entire time so they did not think it was an elopement or reportable incident. The incident report and progress notes from the 10/05/2024 incident were reviewed with Staff A and they were asked to show where in the incident report or progress notes it showed that staff were with the resident throughout the entire incident, as the incident report was from the perspective of a staff member sitting in their car in the parking lot and seeing the staff running after the resident down the side of the road after the resident had climbed over the fence. Staff A stated there was no documentation or witness statements to support that staff were with the resident throughout the entire event of eloping. Staff A was reminded that the resident had a fall into a ditch after eloping from a secured memory care unit, and Staff A confirmed that was a reportable incident to CRU. Staff C, Director of Operations, confirmed both incidents should have been reported.

This is an uncorrected and recurring deficiency previously cited on 08/05/2024 and 01/10/2023.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 06/06/2025.

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

Director of Operations

Patricia Santos-Love

Administrator (or Representative)

May 22, 2025

Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation, or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated, and

did they move the female resident away from R1 and monitor them closely as they did. Staff B stated the event occurred at night and they obtained permission after the fact. Staff B was asked if there was any documentation of these conversations with the family and Staff B confirmed there was no documentation of conversation with the families.

In an interview on 04/16/2025 at 3:41PM, Staff A was asked how they ruled out abuse and neglect for the elopement incident for R1 on 10/05/2024, and they stated staff were with the resident the entire time so they did not think it was an elopement or reportable incident. The incident report and progress notes from the 10/05/2024 incident were reviewed with Staff A and they were asked to show where in the incident report or progress notes it showed that staff were with the resident throughout the entire incident, as the incident report was from the perspective of a staff member sitting in their car in the parking lot and seeing the staff running after the resident down the side of the road after the resident had climbed over the fence. Staff A stated there was no documentation or witness statements to support that staff were with the resident throughout the entire event of eloping. Staff A was reminded that the resident had a fall into a ditch after eloping from a secured memory care unit, and Staff A confirmed that was a reportable incident to CRU. Staff C, Director of Operations, confirmed both incidents should have been reported.

This is an uncorrected and recurring deficiency previously cited on 08/05/2024 and 01/10/2023.

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, Memory Care At The Lodges 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-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the secured memory care assisted living facility failed to investigate and document investigative actions and findings for 1 of 4 incidents reviewed. These failures placed 42 of 42 residents at risk for ongoing abuse and neglect, unmet care needs, and decreased quality of life.

Findings included…

Record review of the "Department of Social And Health Services" document, Completion date 08/05/2024, 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 (Washington Administrative Code) 388-78A-2371] 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, Administrator, signed the document on 08/27/2024. 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 09/19/2024."

Record review of the facility policy, titled, "Abuse and Neglect-Resident," dated 02/15/2024, stated, "This Community will make every reasonable effort to ensure the safety and wellbeing of our residents and staff and promote a healthy atmosphere free of abuse, neglect, or exploitation. The community will not hire or continue to employ persons with a history of or propensity for abuse in accordance with Guidelines found in the DSHS Assisted Living Guidebook: Partners in Protection. Based on RCW 70.129 Resident Rights, WAC 388-78A-2660, WAC 388-78A-2630…All staff members and residents will be educated about abuse and neglect in the assisted living setting, including definitions, prevention, awareness, investigation and reporting…All allegations of abuse or neglect will be treated as serious and will be investigated, documented and reported per the standards set forth in this policy and procedure…Failure to follow the policy and procedure as set forth will be considered a serious violation of employee responsibilities and will result in disciplinary action up to and including discharge." Under section "Definitions," it stated, "Neglect: for the purpose of this policy, Neglect means the active or passive failure to provide the basic care or services necessary to maintain the health and safety of an adult, when that failure results in physical harm, significant emotional harm, unreasonable discomfort, or serious loss of personal dignity to the adult; or creates the risk of serious harm to the adult. The expectation for care may exist because of an assumed responsibility or a legal contractual agreement, including, but no limited to, where an individual has a fiduciary responsibility to assure the continuation of necessary care or services. An adult, who in good faith, is voluntarily under treatment solely by spiritual means in accordance with the tenets and practices of a recognized church or religious denomination shall, for this reason alone, not be considered subjected to abuse by reason of neglect as defined in these rules." Under section, titled, "D. Investigation of Alleged Abuse or Neglect," stated, "Resident safety

will be ensured, and medical treatment or supportive services will be provided as necessary. The resident Primary Care Provider will be notified if indicated…As soon as feasible, the supervisor or manager on duty will report the incident to the Health Services Director, Administrator, and to the appropriate state agency, following the guidelines for mandatory reporting and will immediately initiate the investigation…The resident and residents responsible party will be reassured that the resident is not in any further danger of alleged abuse and that the Community is committed to conducting a thorough and prompt investigation…The investigator will follow the guidelines and process in the “Investigation Protocol”…All staff who might have witnessed or have knowledge of the alleged abuse will be interviewed using the “Allegation Interview Form” form…”

Resident 1 (R1)
Record review of a progress note for R1, dated 10/18/2024, showed staff reported that R1 had another female resident with him in bed and that R1 had his pants down. The female resident's brief [undergarments for adults] was partially removed. The female resident presented in daze and confused condition at the time she was found. R1 stated he had permission from the family and that the female resident was his fiancé (she was not his fiancé). The female resident was removed from the situation and placed in a different room away from R1. Both residents were placed on monitoring with 15 minute checks being conducted. The administrator was notified of the incident.

Record review of the incident log and incident reports, dated 09/20/2024-03/21/2025, showed there was no incident report for the incident on 10/18/2024.

In an interview on 04/16/2025 at 1:38PM, Staff B, Health and Wellness Director/Nurse, and Staff A confirmed no incident/investigation report was completed for the incident with R1 on 10/18/2024. When asked if the event on 10/18/2024 should have been reported to complaint resolution unit (CRU), Staff B stated he didn’t think so as he did not think the event was sexual abuse because the families didn’t have a problem with it. Documentation was requested showing the family was notified and approved of the residents having intimate relations, and Staff B stated they didn’t know if they had documentation. Staff B was asked, if they had permission for the resident to have intimate relationships why did they move the female resident away from R1 and monitor them closely as they did. Staff B stated the event occurred at night and they obtained permission after the fact. Staff B was asked if there was any documentation of the conversations with the family and Staff B confirmed there was no documentation of conversations with the families.

This is an uncorrected and recurring deficiency previously cited on 08/05/2024, 04/27/2023, and 01/10/2023.

Statement of Deficiencies	License # 2600	Compliance Determination # 58171
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 8 of 8	Licensee: Greenlake Management Lacey, LLC	05/14/2025

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) 06/06/2025 .

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

Director of Operations

Patricia Santos-Love
Administrator (or Representative)

May 22, 2025
Date

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)_____ .

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

_____ _____

Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2600
Intake ID: 138200
Compliance Determination #: 44383
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 07/19/2024 through 08/05/2024
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Report of residents being found the next morning soaked in urine and wearing the same clothes as the previous morning.
2. Administration/Personnel: Report of residents being found the next morning soaked in urine and wearing the same clothes as the previous morning.
3. Physical Environment: Report of facility being infested with bed bugs and not having adequate housekeeping.
4. Resident/Patient/Client Neglect: Report of residents being found the next morning soaked in urine and wearing the same clothes as the previous morning.

Investigation Methods:

Sample:
Total residents: 47
Resident sample size: 3
Closed records sample size: 0

Observations:
Identified resident
Residents
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Nursing staff
Residents
Guardian
Business office manager

Record Reviews:
State reporting log
Incident investigation
Facility policies
Personnel files
Care Plan
Progress notes
Incident Log
Characteristic Roster
Care Plan

Receipt
Staff List
Staff Schedule

Investigation Summary:

1. Quality of Care/Treatment: Facility failed to ensure that care and services were provided to residents after resident found in wet briefs and wet bedding. Failed practice identified. Unable to substantiate that residents clothes not being changed.
Facility failed to keep on file required background check documentation for staff. Failed practice identified.
Facility failed to notify the Complaint Resolution Unit when an allegation of abuse was brought to their attention. Failed practice identified.
Facility failed to investigate an incident and document findings. Failed practice identified.
2. Administration/Personnel: Facility failed to ensure that care and services were provided to residents after resident found in wet briefs and wet bedding. Failed practice identified. Unable to substantiate that residents clothes not being changed.
3. Physical environment: Facility has hired professionals to address bed bugs and housekeeper is back from leave to address housekeeping issues. No failed practice identified.
4. Resident/Patient/Client Neglect: Facility failed to ensure that care and services were provided to residents after resident found in wet briefs and wet bedding. Failed practice identified. Unable to substantiate that residents clothes not being changed.

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

Statement of Deficiencies	License #: 2600	Compliance Determination # 44383
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 1 of 11	Licensee: Greenlake Management Lacey, LLC	08/05/2024

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 complaint investigation on 07/19/2024 and 08/05/2024 of:

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

This document references the following complaint number(s): 138200

The following sample was selected for review during the unannounced on-site visit: 3 of 47 current residents and 0 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

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

08/16/2024
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.

The department completed data collection for an unannounced on-site complaint investigation on 07/19/2024 and 08/05/2024 of:

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

This document references the following complaint number(s): 138200

The following sample was selected for review during the unannounced on-site visit: 3 of 47 current residents and 0 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

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) 8.27.24 Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

(b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a Washington State name and date-of-birth background check was completed for 3 of 3 sampled staff (Staff C, Staff D, and Staff E). This failure placed 47 of 47 residents at risk for being cared for by staff members with potentially disqualifying history.

Findings included...

Record review of the facility's policy titled, "Abuse and Neglect-Resident", dated 02/15/2024, under the section titled, "Hiring Process," showed, "1. Requests for Criminal background checks will be sent to the appropriate agency, for all staff prior to or upon hire, in accordance with WAC 388-78A-2461 through WAC 388-78A-24701."

Record review of an email sent to the department on 08/01/2024 at 12:30 PM, Staff A, Executive Director, stated Staff C, Caregiver, was hired on 11/15/2014.

Record review of Staff C's employee file showed there was no Washington State name-and-date-of-birth background check available for review.

In an interview on 07/19/2024 at 12:07 PM, Staff B, Business Office Manager, was asked to provide Staff C's Washington state name and date of birth background check. Staff B stated it would be in the binder. Staff B was asked to look for it in the binder, they stated its not in there.

Record review of an email sent to the department on 07/30/2024 at 1:44 PM, Staff A stated, Staff D, Caregiver, was hired on 01/19/2023.

Administrator (or Representative) Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

(b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a Washington State name and date-of-birth background check was completed for 3 of 3 sampled staff (Staff C, Staff D, and Staff E). This failure placed 47 of 47 residents at risk for being cared for by staff members with potentially disqualifying history.

Findings included…

Record review of the facility's policy titled, "Abuse and Neglect-Resident", dated 02/15/2024, under the section titled, "Hiring Process," showed, "1. Requests for Criminal background checks will be sent to the appropriate agency, for all staff prior to or upon hire, in accordance with WAC 388-78A-2461 through WAC 388-78A-24701."

Record review of an email sent to the department on 08/01/2024 at 12:30 PM, Staff A, Executive Director, stated Staff C, Caregiver, was hired on 11/15/2014.

Record review of Staff C's employee file showed there was no Washington State name-and-date-of-birth background check available for review.

In an interview on 07/19/2024 at 12:07 PM, Staff B, Business Office Manager, was asked to provide Staff C's Washington state name and date of birth background check. Staff B stated it would be in the binder. Staff B was asked to look for it in the binder, they stated its not in there.

Record review of an email sent to the department on 07/30/2024 at 1:44 PM, Staff A stated, Staff D, Caregiver, was hired on 01/19/2023.

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Record review on 07/19/2024 at 10:00 AM, of Staff D's employee file showed there was no Washington State name-and-date-of-birth background check available for review.

In an interview on 07/19/2024 at 11:06 AM, Staff A was asked to provide Staff D's Washington state name and date of birth background check. Staff A was unable to provide it.

Record review of an email sent to the department on 07/30/2024 at 1:44 PM, Staff A stated, Staff E, Caregiver, was hired on 06/06/2024.

Record review of Staff E's employee file showed there was no Washington State name-and-date-of-birth background check available for review.

In an interview on 07/19/2024 at 10:45 AM, Staff A was asked if they had Staff E's Washington state name and date of birth background check available for review. Staff A stated, we don't generally run background checks for agency staff. The agency runs it for us.

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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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 9/24/24 9/19/24 (R)

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

Administrator (or Representative) _____ Date 8.22.24

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

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

Record review on 07/19/2024 at 10:00 AM, of Staff D's employee file showed there was no Washington State name-and-date-of-birth background check available for review.

In an interview on 07/19/2024 at 1106 AM, Staff A was asked to provide Staff D's Washington state name and date of birth background check. Staff A was unable to provide it.

Record review of an email sent to the department on 07/30/2024 at 1:44 PM, Staff A stated, Staff E, Caregiver, was hired on 06/06/2024.

Record review of Staff E's employee file showed there was no Washington State name-and-date-of-birth background check available for review.

In an interview on 07/19/2024 at 10:45 AM, Staff A was asked if they had Staff E's Washington state name and date of birth background check available for review. Staff A stated, we don't generally run background checks for agency staff. The agency runs it for us.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2630 Reporting abuse and neglect.

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(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

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to immediately report neglect to the department's Complaint Resolution Unit for 3 of 3 residents (Resident 1 [R1], Resident 2 [R2], and Resident 3 [R3]) reviewed. This failure placed 47 of 47 residents at risk for neglect and unmet care needs.

Findings included…

"RCW 74.34.035 Reports—Mandated and Permissive—Contents—Confidentiality. (1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department."

Record review of Assisted Living Facility Guidebook, dated February 2018, showed to report to the department when there was reasonable cause to believe violations had occurred involving abuse, neglect, abandonment, significant injuries of unknown source, or personal and/or financial exploitation.

Record review of facility policy, titled, "Abuse and Neglect-Resident," dated 02/15/2024, stated, "This Community will make every reasonable effort to ensure the safety and wellbeing of our residents and staff and promote a healthy atmosphere free of abuse, neglect, or exploitation. The community will not hire or continue to employ persons with a history of or propensity for abuse in accordance with Guidelines found in the DSHS Assisted Living Guidebook: Partners in Protection. Based on RCW 70.129 Resident Rights, WAC 388-78A-2660, WAC 388-78A-2630…All staff members and residents will be educated about abuse and neglect in the assisted living setting, including definitions, prevention, awareness, investigation and reporting…All allegations of abuse or neglect will be treated as serious and will be investigated, documented and reported per the standards set forth in this policy and procedure…Failure to follow the policy and procedure as set forth will be considered a serious violation of employee responsibilities and will result in disciplinary action up to and including discharge." Under section "Definitions," it stated, "Neglect: for the purpose of this policy, Neglect means the active or passive failure to provide the basic care or services necessary to maintain the health and safety of an adult, when that failure results in physical harm, significant emotional harm, unreasonable discomfort, or serious loss of personal dignity to the adult; or creates the risk of serious harm to the adult. The expectation for care may exist because of an assumed responsibility or a legal contractual agreement, including, but no limited to, where an individual has a fiduciary responsibility to assure the continuation of necessary care or services. An adult, who in good faith, is voluntarily under treatment solely by spiritual means in accordance with the tenets and practices of a recognized church or religious denomination shall, for this reason alone, not be considered subjected to abuse by reason of neglect as defined in these rules." Under the section, titled, "C. Reporting Witnessed or Suspected Abuse or Neglect," stated, " The alleged abuse will be immediately reported by the person who witnessed it, to the supervisor on duty, or the Administrator, and to the appropriate state agency, following the guidelines for mandatory reporting…An incident report will be completed, and the state mandated reporting will be completed and submitted in accordance with state

regulations."

Record review of a report to the department on 07/11/2024 at 7:02 PM, showed a report of multiple residents being left unchanged throughout the night and soaked in urine including R1, R2, and R3. There was no facility report of this incident made to the department.

In an interview on 07/24/2024 at 4:39PM, Collateral Contact 2 (CC2), anonymous staff, was asked what the process was when they come on shift and discovered a resident had been left in a wet brief for an extended period of time. CC2 stated they report it to the medication technician and then report it to the Resident Care Coordinator (RCC). CC2 stated they then clean the resident and change the bed sheets. CC2 stated it happened a lot. CC2 was asked who they had seen this happen to. They stated R1, R2, R3 and another resident. CC2 was asked what happened when they reported it, they stated nothing. CC2 was asked how often these residents should be changed, they stated, "we all know they are heavy wetters and should be changed every two hours." CC2 stated they need to strip R1's bed every time they go in their room, and that it was drenched in urine along with R1's clothes and bedding, down to the mattress. CC2 stated R1 and R2 were the two that were really bad.

In an interview on 07/19/2024 at 10:42 AM, Staff A, Executive Director, was asked if they were aware of an allegation of residents being left in wet briefs. Staff A stated it had been reported to them. Staff A was asked if leaving residents in wet briefs was neglect, Staff A stated it can be. Staff A was asked if neglect was a form of abuse, Staff A stated yes. Staff A was asked if they were required to report abuse, Staff A stated, yes, if there was suspected abuse and neglect.

In an interview on 07/24/2024 at 12:49 PM, Staff F, Resident Care Coordinator, was asked what the policy stated regarding reporting. They stated that any abuse neglect or danger should be reported within 2 hours to the State. Staff F was asked if residents being left in wet briefs was considered suspected abuse and Staff F stated it would be suspected neglect and that the caregiver would be placed on suspension pending an investigation. Staff F was asked if that would be reported right away, and they stated after the internal investigation then it would be if it was found to be neglect or abuse. Staff F was asked if the incident should have been reported to the State regardless of what the investigation stated, and Staff F stated the incidents involving R1, R2 and R3 should have been reported regardless.

This is a recurring deficiency previously cited on 01/10/2023.

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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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 9/21/24 9/19/24.

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

Administrator (or Representative) 8.22.24 Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document investigative actions and findings for an incident for 3 of 3 residents (Resident 1 [R1], Resident 2 [R2], and Resident 3 [R3]). These failures resulted in all three residents not having measures to prevent reoccurrences of unmet care needs, at risk for developing skin issues, and placed R1, R2 and R3 at risk for a decreased quality of life.

Findings included..

Record review of the facility policy, titled, "Abuse and Neglect-Resident," dated 02/15/2024, stated, "This Community will make every reasonable effort to ensure the safety and wellbeing of our residents and staff and promote a healthy atmosphere free of abuse, neglect, or exploitation. The community will not hire or continue to employ persons with a history of or propensity for abuse in accordance with Guidelines found in the DSHS Assisted Living Guidebook: Partners in Protection. Based on RCW 70.129 Resident Rights, WAC 388-78A-2660, WAC 388-78A-2630...All staff members and residents will be educated about abuse and neglect in the assisted living setting, including definitions, prevention, awareness, investigation and reporting...All allegations of abuse or neglect will be treated as serious and will be investigated, documented and reported per the standards set forth in this policy and procedure...Failure to follow the policy and procedure as set forth will be considered a serious violation of employee responsibilities and will result in disciplinary action up to and including discharge." Under section "Definitions," it stated, "Neglect: for the purpose of this policy, Neglect

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Administrator (or Representative) Date

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Findings included…

Record review of the facility policy, titled, “Abuse and Neglect-Resident,” dated 02/15/2024, stated, “This Community will make every reasonable effort to ensure the safety and wellbeing of our residents and staff and promote a healthy atmosphere free of abuse, neglect, or exploitation. The community will not hire or continue to employ persons with a history of or propensity for abuse in accordance with Guidelines found in the DSHS Assisted Living Guidebook: Partners in Protection. Based on RCW 70.129 Resident Rights, WAC 388-78A-2660, WAC 388-78A-2630…All staff members and residents will be educated about abuse and neglect in the assisted living setting, including definitions, prevention, awareness, investigation and reporting…All allegations of abuse or neglect will be treated as serious and will be investigated, documented and reported per the standards set forth in this policy and procedure…Failure to follow the policy and procedure as set forth will be considered a serious violation of employee responsibilities and will result in disciplinary action up to and including discharge.” Under section “Definitions,” it stated, “Neglect: for the purpose of this policy, Neglect

means the active or passive failure to provide the basic care or services necessary to maintain the health and safety of an adult, when that failure results in physical harm, significant emotional harm, unreasonable discomfort, or serious loss of personal dignity to the adult; or creates the risk of serious harm to the adult. The expectation for care may exist because of an assumed responsibility or a legal contractual agreement, including, but no limited to, where an individual has a fiduciary responsibility to assure the continuation of necessary care or services. An adult, who in good faith, is voluntarily under treatment solely by spiritual means in accordance with the tenets and practices of a recognized church or religious denomination shall, for this reason alone, not be considered subjected to abuse by reason of neglect as defined in these rules." Under section, titled, "D. Investigation of Alleged Abuse or Neglect," stated, "Resident safety will be ensured, and medical treatment or supportive services will be provided as necessary. The resident Primary Care Provider will be notified if indicated…As soon as feasible, the supervisor or manager on duty will report the incident to the Health Services Director, Administrator, and to the appropriate state agency, following the guidelines for mandatory reporting and will immediately initiate the investigation…The resident and residents responsible party will be reassured that the resident is not in any further danger of alleged abuse and that the Community is committed to conducting a thorough and prompt investigation…The investigator will follow the guidelines and process in the "Investigation Protocol"…All staff who might have witnessed or have knowledge of the alleged abuse will be interviewed using the "Allegation Interview Form" form…"

Record review of a report to the department on 07/11/2024 at 7:02 PM, showed a report of multiple residents being left unchanged throughout the night and soaked in urine including R1, R2, and R3. There was no facility report of this incident.

In an interview on 07/24/2024 at 4:39PM, Collateral Contact 2 (CC2), anonymous staff, was asked what the process was when they come on shift and discovered a resident had been left in a wet brief for an extended period of time. CC2 stated they report it to the medication technician and then report it to the Resident Care Coordinator (RCC). CC2 stated they then clean the resident and change the bed sheets. CC2 stated it happened a lot. CC2 was asked who they had seen this happen to. They stated R1, R2, R3 and another resident. CC2 was asked what happened when they reported it, they stated nothing. CC2 was asked how often these residents should be changed, they stated, "we all know they are heavy wetters and should be changed every two hours." CC2 stated they need to strip R1's bed every time they go in their room, and that it was drenched in urine along with R1's clothes and bedding, down to the mattress. CC2 stated R1 and R2 were the two that were really bad.

In an interview on 07/19/2024 at 10:42AM, Staff A, Executive Director, was asked if they were aware of residents being left in wet briefs for an extended period of time recently, Staff A verbalized knowledge of the incident. Staff A stated it had been reported to them and they were waiting for Staff E, caregiver, to show up for work. Staff E didn't show up for work and was therefore not coming back to the facility to work. Staff A was asked if they conducted an investigation, they stated, no, they did not and by then the residents

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briefs had already been changed. Staff A stated that they talked to the med tech (medication technician) and the caregiver. Staff A stated they were told that, "R2 and R3 definitely were not changed."

In an interview on 07/24/2024 at 12:49 PM, Staff F, Resident Care Coordinator, was asked if residents being left in wet briefs for an unknown amount of time an allegation that should have been investigated, Staff F stated, yes, if we were made aware of residents being left in wet briefs it would be immediately investigated and documented

This is a recurring deficiency previously cited on 04/27/2023 and 01/10/2023.

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, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 9/21/24 9/14/24

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

Administrator (or Representative) 8-22-24 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;

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

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to ensure that care and services provided to residents maintained or enhanced each resident's dignity for 3 of 3 residents reviewed (Resident 1 [R1], Resident 2 [R2], and Resident 3 [R3]). This failure resulted in all three residents not receiving dignified and required incontinence care, placed all three residents at risk for developing skin issues, and placed 47 of 47 residents at risk for unmet care needs and decreased quality of life.

Findings included...

briefs had already been changed. Staff A stated that they talked to the med tech (medication technician) and the caregiver. Staff A stated they were told that, “R2 and R3 definitely were not changed.”

In an interview on 07/24/2024 at 12:49 PM, Staff F, Resident Care Coordinator, was asked if residents being left in wet briefs for an unknown amount of time an allegation that should have been investigated, Staff F stated, yes, if we were made aware of residents being left in wet briefs it would be immediately investigated and documented.

This is a recurring deficiency previously cited on 04/27/2023 and 01/10/2023.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

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(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;

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

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to ensure that care and services provided to residents maintained or enhanced each resident’s dignity for 3 of 3 residents reviewed (Resident 1 [R1], Resident 2 [R2], and Resident 3 [R3]). This failure resulted in all three residents not receiving dignified and required incontinence care, placed all three residents at risk for developing skin issues, and placed 47 of 47 residents at risk for unmet care needs and decreased quality of life.

Findings included…

"RCW 70.129.140 Quality of life—Rights.(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."

"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."

Record review of a report to the department on 07/11/2024 at 7:02 PM, showed a report of multiple residents, including R1, R2 and R3, being left unchanged throughout the night and soaked in urine.

In an observation on 07/19/2024 at 6:44 AM , there was a strong pungent smell of urine in a room across from the medication room in Lodge 1.

In an observation on 07/19/2024 at 7:09 AM, Room [redacted] had a strong smell of urine upon entry into the residents room.

Record review of R1's face sheet, dated 07/22/2024, showed that R1 was admitted to the facility on [redacted]/2024.

Record review of R1's Needs and Services Plan (care plan), last reviewed on [redacted]/2024, under the "Toileting-Incontinence" category stated, "Total Assist", under interventions showed, "[R1] requires 1 person total assistance with toileting. Extensive incontinence checks and/or changes daily. [R1]is incontinent of both bowel and bladder."

Record review of R2's face sheet, dated 07/22/2024, showed that R2 was admitted to the facility on [redacted]/2024.

Record review of R2's Needs and Services Plan (care plan), last reviewed on [redacted]/2024, under the "Toileting" category, it stated, "Standby Assist, incontinent of bladder and occasional bowel. Wears briefs."

Record review of R3's face sheet, dated 07/22/2024, showed that R3 was admitted to the facility on [redacted]/2024.

Record review of R3's Needs and Services Plan (care plan), last reviewed on 02/26/2024, under the "Toileting" category stated, "Total Assist, incontinent of bladder."

In an interview on 07/24/2024 at 4:39PM, Collateral Contact 2 (CC2), anonymous staff, was asked what the process was when they come on shift and discovered a resident had been left in a wet brief for an extended period of time. CC2 stated they report it to the medication technician and then report it to the Resident Care Coordinator (RCC). CC2 stated they then clean the resident and change the bed sheets. CC2 stated it happened a lot. CC2 was asked who they had seen this happen to. They stated R1, R2, R3 and another resident. CC2 was asked what happened when they reported it, they stated nothing. CC2 was asked how often these residents should be changed, they stated we all know they are "heavy wetters and should be changed every two hours." CC2 stated they need to strip R1's bed every time they go in their room, and that it was drenched in urine along with R1's clothes and bedding, down to the mattress. CC2 stated R1 and R2 were the two that were really bad.

In an observation on 07/19/2024 at 7:51 AM, R1 was lying in bed with blanket bunched up on the top half of their body. Visible were R1' s navy blue sweats. Sweats appeared darker in color from the knees up to the waist band. The room smelled of urine.

In an interview on 07/19/2024 at 7:51 AM, Staff G, Caregiver, stated R1 was wet and their bed was wet too.

In an observation on 07/19/2024 at 7:51 AM, the other bed in R1's room, that was vacant, had an 18 inch by 18 inch wet spot on the green blanket. Under the green blanket had a smaller circle on the sheet that was also wet.

In an observation on 07/19/2024 at 8:04AM, after reentering R1's room after the bedding was changed by Staff G, Caregiver, R1's room smelled strongly of urine odor . R1's brief appeared heavy and saturated with yellow liquid. Staff G was asked to hold up R1s's navy blue sweatpants. The sweatpants from the knees up to the waist band, on the front and back side, appeared darker in color and wet. Staff G was asked to hold up R1's black T shirt. Staff G was asked if the t-shirt was wet. They replied it was. Staff G proceeded to strip R1's bed. Plaid bed pad on R1's bed appeared heavy and very saturated with liquid. Under the bed pad revealed a wet spot on the sheet. Staff G pulled the sheet off the mattress revealing a darker area, under where the bed pad was, appearing to be moisture. On the side of the box spring under the mattress, in the middle, appeared a brown smudge from the top of the box spring down to the bottom. On the foot end side of the box spring corner, from the top to the bottom of the corner, was a similar brown smudge.

In an interview on 08/05/2024 at 3:13 PM, Collateral Contact 3 (CC3), anonymous staff, was asked what the process was when they come on shift and discovered a resident

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had been left in a wet brief for an extended period of time. They stated they report it to the Executive Director. CC3 stated they will then get them cleaned up. CC3 was asked if they had seen any residents left in urine for an extended period of time. They stated R1, R2, and R3. CC3 stated they have seen R1 laying in their bed soaking wet and had seen them walk out of their room soaking wet. CC3 stated R1's pants were soaked, brief dangling, shirt was wet, and bedding was soaked.

In an interview on 08/01/2024 at 11:38 AM, Collateral Contact 1 (CC1), anonymous staff, was asked if they had encountered any residents left in wet briefs for an extended period of time. They stated yes. CC1 stated it happened to R1, R2, R3 and other residents. CC1 stated they report it to the medication technician. CC1 was asked how often care staff were to go into residents' rooms to check on them. They stated standard was to check and change every two hours. CC1 stated based off of what they had seen with the saturation and the smell, it had been longer than two hours. CC1 stated that they had seen R1 walk out from their room, and they were soaking wet and if they were still in bed they were soaking wet. CC1 stated R1's clothes, bed pad, sheets, flat sheet and mattress were soaked .

In an interview on 07/19/2024 at 10:42AM, Staff A, Executive Director, was asked if they were aware of residents being left in wet briefs for an extended period of time recently, Staff A verbalized knowledge of the incident. Staff A stated it had been reported to them and they waited for Staff E, caregiver, to show up for work to talk to them. Staff E didn't show up for work and was not coming back to the facility to work. Staff A was asked if they conducted an investigation, they stated, no, they did not and by then the residents had already been changed. Staff A stated that they talked to the medication technician and the caregiver, Staff A stated they were told that, "R2 and R3 definitely were not changed."

This is a recurring deficiency previously cited on 01/10/2023 for subsections (1)(2)

Plan/Attestation Statement

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Administrator (or Representative) 8.22.24 Date

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In an interview on 08/01/2024 at 11:38 AM, Collateral Contact 1 (CC1), anonymous staff, was asked if they had encountered any residents left in wet briefs for an extended period of time. They stated yes. CC1 stated it happened to R1, R2, R3 and other residents. CC1 stated they report it to the medication technician. CC1 was asked how often care staff were to go into residents' rooms to check on them. They stated standard was to check and change every two hours. CC1 stated based off of what they had seen with the saturation and the smell, it had been longer than two hours. CC1 stated that they had seen R1 walk out from their room, and they were soaking wet and if they were still in bed they were soaking wet. CC1 stated R1's clothes, bed pad, sheets, flat sheet and mattress were soaked .

In an interview on 07/19/2024 at 10:42AM, Staff A, Executive Director, was asked if they were aware of residents being left in wet briefs for an extended period of time recently, Staff A verbalized knowledge of the incident. Staff A stated it had been reported to them and they waited for Staff E, caregiver, to show up for work to talk to them. Staff E didn't show up for work and was not coming back to the facility to work. Staff A was asked if they conducted an investigation, they stated, no, they did not and by then the residents had already been changed. Staff A stated that they talked to the medication technician and the caregiver. Staff A stated they were told that, "R2 and R3 definitely were not changed."

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Administrator (or Representative) Date