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

04/22/2025

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) 58348 (Completion Date 04/22/2025) and 53154 (Completion Date 01/28/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/22/2025 and found no deficiencies.

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

The Department staff who did the Off Site verification:
Nikolas Jennings, Community Nurse Complaint Investigator

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

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 off-site follow-up on 01/15/2025 of:

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

This document references the following SOD dated: 01/28/2025

The following sample was selected for review during the unannounced off-site verification: 6 of 48 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Nikolas Jennings, Community Nurse 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 off-site verification(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

02/06/2025
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.

2.7.25 PIE
2/7/25 3.14.25

Administrator (or Representative)

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 obtain medications in a timely manner for 1 of 6 sampled residents (Resident 4 [R4]). This failure resulted in R4 not receiving medications as prescribed and placed the resident at risk for medical complications and decreased quality of life.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 11/25/2024, 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 388-78A-2240] 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 B, Executive Director, signed the document on 12/12/2024. Staff B 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 01/04/2025."

Record review of the facility policy, titled, "Medication Non-Availability", undated, showed "For medications that are not included in a cycle refill system, a refill will be requested from the appropriate pharmacy when there is a 10-day supply of the

medication remaining."

Record review of R4's face sheet, undated, showed an admission date of 11/15/2024.

Record review of R4's Medication administration record (MAR), dated 01/01/2025-01/31/2025, showed levalbuterol (a medication given to help with breathing) was not given for reason "Waiting medication delivery" for the dates of 01/05/2025, 01/06/2025, 01/07/2025, 01/08/2025, 01/09/2025, 01/10/2025, 01/11/2025, 01/12/2025, 01/13/2025, 01/14/2025, and 01/15/2025. This resulted in 30 missed doses. This medication had an order origination date of 11/03/2024.

Record review of R4's MAR, dated 01/01/2025-01/31/2025, showed trazadone (an antidepressant frequently given to help with sleep) was not given for reason "Waiting medication delivery" for the dates of 01/05/2025, 01/06/2025, 01/07/2025, 01/08/2025, 01/10/2025, 01/11/2025, 01/12/2025, 01/13/2025, and 01/14/2025. This resulted in nine missed doses. This medication had an order origination date of 11/03/2024.

Record review of R4's MAR, dated 01/01/2025-01/31/2025, showed quetiapine (an antipsychotic frequently given to help with agitation) was not given for reason "Waiting medication delivery" for the dates of 01/05/2025, 01/06/2025, 01/08/2025, 01/10/2025, 01/11/2025, 01/12/2025, 01/13/2025, and 01/14/2025. This resulted in eight missed doses. This medication had an order origination date of 11/03/2024.

Record review of R4's MAR, dated 01/01/2025-01/31/2025, showed Drizalma (an antidepressant medication to help with pain) was not given for reason "Waiting medication delivery" for the dates of 01/05/2025, 01/06/2025, 01/07/2025, 01/08/2025, 01/10/2025, 01/11/2025, 01/12/2025, 01/13/2025, and 01/14/2025. This resulted in nine missed doses. This medication had an order origination date of 11/03/2024.

Record review of R4's MAR, dated 01/01/2025-01/31/2025, showed on 01/10/2025, Staff B, Resident Care Coordinator, was to give Trazadone, Quetiapine, Levalbuterol, and Drizalma, and noted that they were not given due to "Waiting medication delivery".

Record review of R4's MAR, dated 01/01/2025-01/31/2025, showed on 01/07/2025 and 01/08/2025, Staff C, Health Services Director, was to give Trazadone, Quetiapine, Levalbuterol, and Drizalma, and noted that they were not given due to "no neb in cart" and "out of medications need refill".

In an interview on 01/28/2025 at 10:46AM, Staff A, Executive director, stated that the medications were not given because they were not available.

This is an uncorrected and recurring deficiency previously cited on 11/20/2024, 09/24/2024, 04/27/2023, and 01/10/2023.

Statement of Deficiencies	License #: 2600	Compliance Determination # 53154
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 4 of 4	Licensee: Greenlake Management Lacey, LLC	01/28/2025

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) 3.14.25 .

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

Administrator (or Representative)

3/14/25 2.7.25
Date

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 11/19/2024 and 11/19/2024 of:

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

This document references the following SOD dated: 11/20/2024

The following sample was selected for review during the unannounced on-site visit: 3 of 52 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Nikolas Jennings, Community Nurse 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

11/25/2024
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) 12.12.24 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 obtain medications in a timely manner for three of three sampled residents (Resident 1 [R1], Resident 2[R2], Resident 3[R3]). This failure resulted in R1, R2, and R3 not receiving medications as prescribed and placed the residents at risk for medical complications and decreased quality of life.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 09/24/2024, 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 388-78A-2240] 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 B, Executive Director, signed the document on 10/16/2024. Staff B 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 11/04/2024."

Record review of the facility policy, titled, "Medication Non-Availability", undated, showed "For medications that are not included in a cycle refill system, a refill will be requested from the appropriate pharmacy when there is a 10-day supply of the medication remaining."

In an interview on 11/19/2024 at 12:08PM, Staff A, Medication Technician, stated some residents had missed medications, and they had asked the person training them how to fix it and was told some of the residents were missing medications because the pharmacy needed new prescriptions.

In an interview on 11/19/2024 at 1120AM, Staff B, Executive Director, stated that they had a new system for notification of management through a new form that was created and that audits were completed by management staff via missing medication reports.

R1:

Record review of R1's Medication Administration Record (MAR), dated 11/01/2024-11/30/2004, showed that Levothyroxine (a medication for low thyroid hormone) was not

given for reason "Other" and "Waiting Medication Delivery" for the dates of 11/01/2024-11/05/2024. This resulted in five missed doses.

Record review of R1's charting notes, dated 08/21/2024-11/12/2024, showed zero documented attempts to notify the pharmacy of the need for medication refills.

R2:

Record review of R2's MAR, dated 10/01/2024-10/31/2024, showed that Quetiapine (an anti-psychotic medication frequently given for behavioral management) was not given for reason "Waiting Medication Delivery" for the dates of 10/13/2024-10/18/2024. This resulted in 11 missed doses.

Record review of R2's charting notes, dated 08/29/2024-11/19/2024, showed zero documented attempts to notify the pharmacy of the need for medication refills.

R3:

Record review of R3's MAR, dated 10/01/2024-10/31/2024, showed that Famotidine (a medication used to treat acid reflux and indigestion) was not given for reason "Waiting Medication Delivery" for the dates of 10/03/2024-10/05/2024. This resulted in five missed doses.

Record review of R3's charting notes, dated 08/24/2024-10/15/2024, showed zero documented attempts to notify the pharmacy of the need for medication refills.

In an interview on 11/20/2024 at 9:55AM, Staff B stated that staff failed to follow their Medication Non-Availability policy and procedures protocol, and needed to be retrained.

This is an uncorrected and recurring deficiency previously cited on 09/24/2024, 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) 1.4.25 .

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

Administrator (or Representative) 11.26.24 Date

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2600
Intake ID: 144565
Compliance Determination #: 46818
Region/Unit #: RCS Region 3 / Unit E
Investigator: Nikolas Jennings
Investigation Date(s): 09/11/2024 through 09/24/2024
Complainant Contact Date(s):

Allegation(s):

1) Injury of unknown origin- Resident found with abrasion to lower back.
2) Quality of care/treatment- Medications not being administered correctly.

Investigation Methods:

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

Observations:
Residents
Activities
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Nursing staff
Residents
Family members
Health Services Director
Executive Director

Record Reviews:
Hospital records
Medical records
Facility policies
Incident investigation
Hospice Notes
Negotiated Service Agreements
Medication administration record
Narcotics log
Financial records

Investigation Summary:

1) Injury of unknown origin- Resident found with abrasion to lower back. Abrasion was no longer present upon investigation and appropriate follow up was concluded by facility. Based on interview and record review there was insufficient evidence to

support failed practice. No failed practice identified.

2) Quality of care/treatment- Medications not being administered correctly. Multiple instances found of residents failing to receive medications due to unavailability. Failure to follow physician orders found during narcotic administration. Multiple facility failed practices 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

Statement of Deficiencies	License #: 2600	Compliance Determination # 46818
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 1 of 8	Licensee: Greenlake Management Lacey, LLC	09/24/2024

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 09/11/2024 and 09/16/2024 of:

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

This document references the following complaint number(s): 141990, 142732, 144565

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:

Nikolas Jennings, Community Nurse 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

10/07/2024
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) 10/16/24 Date

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to have a written plan in place for obtaining medications for when a family member is unable or unwilling to fulfill their duties of obtaining medications for 2 of 2 sampled residents (Resident 1[R1] and Resident 2 [R2]). This failure placed R1 and R2 at risk for not receiving medications as prescribed, a decreased quality of life, and placed all 47 of 47 residents at risk for unmet care needs.

Findings included ..

Record review of the facility policy, titled, "Medication Non-Availability", undated, showed "If the resident's responsible party purchases medications for the resident, they will be notified when the supply is at the 10-day level. If the refill has not yet been provided when the medication supply reaches the 5-day level a second notification will be given to the responsible party. The notification will be documented in the Resident's health record. If after the second notification, the responsible party does not obtain the necessary medication and there is only a 3-day supply remaining, the community will obtain the necessary medication from a pharmacy of the community's choice. This will be documented in the Resident's health record."

On 09/11/2024 at 1:39 PM written primary plans were requested for R1 and R2 in the event that their families were unable to fulfill their duties to provide medications for them. The facility was unable to provide a written primary plan for R1 or R2.

In an interview on 09/18/2024 at 10:02 AM, Staff A, Executive Director, stated the facility did not follow their policy in relation to medication non availability. Staff A stated that R2 did not currently have a written plan in place.

Administrator (or Representative) Date

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to have a written plan in place for obtaining medications for when a family member is unable or unwilling to fulfill their duties of obtaining medications for 2 of 2 sampled residents (Resident 1[R1] and Resident 2 [R2]). This failure placed R1 and R2 at risk for not receiving medications as prescribed, a decreased quality of life, and placed all 47 of 47 residents at risk for unmet care needs.

Findings included...

Record review of the facility policy, titled, "Medication Non-Availability", undated, showed "If the resident's responsible party purchases medications for the resident, they will be notified when the supply is at the 10-day level. If the refill has not yet been provided when the medication supply reaches the 5-day level a second notification will be given to the responsible party. The notification will be documented in the Resident's health record. If after the second notification, the responsible party does not obtain the necessary medication and there is only a 3-day supply remaining, the community will obtain the necessary medication from a pharmacy of the community's choice. This will be documented in the Resident's health record."

On 09/11/2024 at 1:38 PM written primary plans were requested for R1 and R2 in the event that their families were unable to fulfill their duties to provide medications for them. The facility was unable to provide a written primary plan for R1 or R2.

In an interview on 09/16/2024 at 10:02 AM, Staff A, Executive Director, stated the facility did not follow their policy in relation to medication non availability. Staff A stated that R2 did not currently have a written plan in place.

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) NOV. 24, 24.

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

Administrator (or Representative) 10/16/24 Date

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to properly administer medications to one of three sampled residents (Resident 1 [R1]). This failure resulted in harm for R1 when their pain medications were not given as prescribed.

Findings included...

Record review of facility policy, titled, "Medication Assistance & Administration", undated, showed, "Medication assistance will be provided to residents in a manner that is safe and by the route directed through the Primary Care Provider's (PCP) orders."

Record review of R1's negotiated service agreement, undated, showed that R1 was unable to self-administer any medications and required total assistance with all medication administration.

Record review of R1's medication administration record (MAR), dated 08/01/2024-08/31/2024, showed oxycodone (a medication for pain management) and acetaminophen (a medication for pain management) scheduled to be given routinely three times daily starting on 08/23/2024.

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, 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-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to properly administer medications to one of three sampled residents (Resident 1 [R1]). This failure resulted in harm for R1 when their pain medications were not given as prescribed.

Findings included...

Record review of facility policy, titled, "Medication Assistance & Administration", undated, showed, "Medication assistance will be provided to residents in a manner that is safe and by the route directed through the Primary Care Provider's (PCP) orders."

Record review of R1's negotiated service agreement, undated, showed that R1 was unable to self-administer any medications and required total assistance with all medication administration.

Record review of R1's medication administration record (MAR), dated 08/01/2024-08/31/2024, showed oxycodone (a medication for pain management) and acetaminophen (a medication for pain management) scheduled to be given routinely three times daily starting on 08/23/2024.

Record review of the facility narcotics book showed facility receipt of oxycodone on 08/17/2024.

Record review of R1's MAR, dated 08/01/2024-08/31/2024, showed the first dosages of routine oxycodone and acetaminophen were given on 08/29/2024. This resulted in 17 missed doses of both medications.

Record review of a progress note for R1, dated 08/13/2024 at 1:42PM, showed "...hospice nurse is ordering pain meds for resident along with hospice bed and fall mat."

Record review of progress notes for R1, dated 08/14/2024 at 7:34AM, showed "resident appeared to be sleepless during the night, resident was in pain, when proving [sic] ADL care resident was yelling and crying about hip pain, No pain meds was[sic] available for resident to take at this time, resident was in her room by end of the shift."

Record review of progress notes for R1, dated 08/15/2024 at 6:33AM, showed "resident has another restless night again, due to on going pain, resident was yelling during the night, did not get much sleep due to being in pain so much, resident was yelling and fighting staff during ADL [activities of daily living] care"

Record review of progress notes for R1, dated 08/15/2024 at 7:59PM, showed "Resident continues to be in pain, still waiting for meds to be delivered."

Record review of progress notes for R1, dated 08/16/2024 at 8:01AM, showed "resident has another restless night, resident was yelling pain most of the night..."

Record review of progress notes for R1, dated 08/16/2024 at 8:05PM, showed "Resident continues to be in pain due to RT [right] HIP replacement..."

In an interview on 09/16/2024 at 10:02 AM, Staff A, Executive Director, when asked if they could explain the gap in medications given stated "no" and stated that "staff failed to follow procedure."

This is a recurring citation previously cited on 04/17/2024 and 01/04/2023.

Plan/Attestation Statement

Statement of Deficiencies	License # 2600	Compliance Determination # 46818
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 5 of 8	Licensee: Greenlake Management Lacey, LLC	09/24/2024

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) NN. 11-29 4 RC

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

Administrator (or Representative) 10/10/24 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 obtain medications in a timely manner for three of three sampled residents (Resident 1 [R1], Resident 2 [R2], and Resident 3 [R3]). This failure resulted in harm when R1 experienced pain from not receiving medications as prescribed and placed all 47 of 47 residents at risk for unmet care needs.

Findings included...

In an interview on 09/11/2024 at 10:49AM with Staff B, Medication Technician, when asked if medications frequently ran out, stated, "they do sometimes, and that it was a large issue when they switched from their in-house doctor to another."

In an interview on 09/11/2024 at 12:01PM with Staff C, Health Service Director, when asked about staff training, stated, "that staff were trained to notify management the first day that a resident was out of medications." When asked what the expectation would be for staff if medication was unavailable, Staff C stated, "that staff should call management and notify the provider or pharmacy for refill."

Record review of resident face sheet undated for R1 showed R1's preferred pharmacy with a phone number listed.

Record review of negotiated service agreement undated for R1 showed that R1 was unable to self-administer any medications and required total assistance with all medication administration.

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-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 obtain medications in a timely manner for three of three sampled residents (Resident 1 [R1], Resident 2 [R2], and Resident 3 [R3]). This failure resulted in harm when R1 experienced pain from not receiving medications as prescribed and placed all 47 of 47 residents at risk for unmet care needs.

Findings included...

In an interview on 09/11/2024 at 10:49AM with Staff B, Medication Technician, when asked if medications frequently ran out, stated, "they do sometimes, and that it was a large issue when they switched from their in-house doctor to another."

In an interview on 09/11/2024 at 12:01PM with Staff C, Health Service Director, when asked about staff training, stated, "that staff were trained to notify management the first day that a resident was out of medications." When asked what the expectation would be for staff if medication was unavailable, Staff C stated, "that staff should call management and notify the provider or pharmacy for refill."

Record review of resident face sheet undated for R1 showed R1's preferred pharmacy with a phone number listed.

Record review of negotiated service agreement undated for R1 showed that R1 was unable to self-administer any medications and required total assistance with all medication administration.

Record review of Medication Administration Record (MAR) for R1, dated 08/01/2024-08/31/2024, showed Oxycodone (a medication for pain management) ordered as needed for pain management on 08/13/2024; Morphine Sulfate (a medication for pain management) ordered as needed for pain management on 08/13/2024; and Oxycodone and Acetaminophen (a medication for pain management) ordered three times routinely per day for pain management on 08/23/2024.

Record review of facility narcotic log showed a fill date of 08/16/2024 for oxycodone and morphine sulfate for R1 and a receipt date of 08/17/2024.

Record review of MAR for R1, dated 08/01/2024-08/31/2024, showed the first date of as needed Oxycodone was given on 08/17/2024 and first date of as needed morphine sulfate on 08/22/2024 and the first dose of routine oxycodone and acetaminophen was given on 08/29/2024.

Record review of a progress note for R1, dated 08/13/2024 at 1:42PM, showed "... hospice nurse is ordering pain meds for resident along with hospice bed and fall mat."

Record review of progress notes for R1, dated 08/14/2024 at 7:34AM, showed "resident appeared to be sleepless during the night, resident was in pain, when proving [sic] ADL care resident was yelling and crying about hip pain, No pain meds was[sic] available for resident to take at this time, resident was in her room by end of the shift."

Record review of progress notes for R1, dated 08/15/2024 at 6:33AM, showed "resident has another restless night again, due to on going pain, resident was yelling during the night, did not get much sleep due to being in pain so much, resident was yelling and fighting staff during ADL [activities of daily living] care"

Record review of progress notes for R1, dated 08/15/2024 at 7:59PM, showed "Resident continues to be in pain, still waiting for meds to be delivered."

Record review of progress notes for R1, dated 08/16/2024 at 8:01AM, showed "resident has another restless night, resident was yelling pain most of the night... "

Record review of progress notes for R1, dated 08/16/2024 at 8:05PM, showed "Resident continues to be in pain due to RT [right] HIP replacement... "

Record review of orders for R1 from hospice, dated 08/13/2024, showed physician orders for oxycodone tablet and morphine sulfate oral solution.

Record review of visit note report for R1 from hospice, dated 08/16/2024, showed "... No start of care medications not in facility. Called pharmacy no orders called hospice for orders tobe [sic] sent to pharmacy. Called .... and left message"

R2

Record review of the MAR for R2, dated 07/01/2024-07/31/2024, showed Ferrous Sulfate (a medication for treating low amounts of iron in the blood) was not given on 07/19/2024-07/31/2024 for reason "Waiting medication delivery". This resulted in 23 missed doses.

Record review of the MAR for R2, dated 08/01/2024-08/31/2024, showed Ferrous Sulfate was not given on 08/01/2024-08/03/2024 for reason "Waiting medication delivery". This resulted in 5 missed doses.

R3

Record review of the MAR for R3, dated 09/01/2024-09/30/2024, showed that Levothyroxine (a medication for thyroid hormone) was not given on 09/04/2024-09/11/2024 for reason "Waiting medication delivery". This resulted in 8 missed doses.

In an interview on 09/11/2024 at 12:01PM with Staff C, when asked about the delay in R1 getting as needed pain medication, Staff C stated, "medications did not arrive until days after R1 got there."

In an interview on 09/11/2024 at 4:02PM with Staff D, Senior Executive Director of a sister facility filling in at the facility for the day, when asked what the longest time frame that they would expect for a resident to be unable to get their pain medication due to unavailability, stated "they would expect 4-6 hours of their staff."

In an interview on 09/16/2024 at 10:02 AM with Staff A, Executive Director, when asked if it was the expectation that medications would be available on return from the hospital, Staff A stated "yes". When asked if they could explain the gap in medications being given, Staff A stated "no". When asked why these concerns occurred, Staff A stated, "staff failed to follow procedure."

In an interview on 09/16/2024 at 10:02 AM with Staff A, when asked if the concerns stated would constitute neglect, Staff A stated "yes, due to a lack of education and procedures being followed."

This is a recurring citation previously cited on 04/17/2024 and 01/04/2023.

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) Nov. 24.24 4 (RV).

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

Administrator (or Representative)

10/16/24
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