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

06/11/2025

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) 60824 (Completion Date 06/11/2025) and 56858 (Completion Date 04/18/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/11/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

(b) Maintain the assisted living facility free of safety hazards; and

(c) Implement fire and disaster plans.

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

The Department staff who did the On Site verification:

Emily Boniface, Community Program Nurse Licensor
Anaya Balter, Community Programs Nurse Licensor and 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 03/27/2025 of:
Memory Care At The Lodges
1530 Carpenter Rd SE
Lacey, WA 98503

This document references the following SOD dated: 04/18/2025

The following sample was selected for review during the unannounced on-site visit: 11 of 45 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Emily Boniface, Community Program Nurse Licensor
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 # 56858
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 2 of 10	Licensee: Greenlake Management Lacey, LLC	04/18/2025

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

04/29/2025
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

5/5/25
Date

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(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

(b) Maintain the assisted living facility free of safety hazards; and

(c) Implement fire and disaster plans.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure they had sufficient staff to meet resident needs for 2 of 2 memory care units (Lodge 1 and Lodge 2) reviewed. This failure placed all 45 of 45 residents at risk for unmet care needs and safety concerns.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 02/13/2025, 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-2450] 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, Executive Director, signed the document on 03/02/2025. 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 03/19/2025."

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.

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 _____

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Findings included…

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Record review of the facility document titled, “Assisted Living Facility Resident Characteristic Roster and Sample Selection,” undated, showed 45 residents resided in the two buildings (lodge 1 and Lodge 2) at the memory care facility. The document showed that all 45 residents had a diagnosis of [redacted] or [redacted]. Of the 45 residents, 23 residents resided in Lodge 1 and 22 residents resided in Lodge Two. Of the 23 residents in Lodge One, 5 residents required maximum assistance, seven required moderate assistance with ADL’s (Activities of Daily Living), five were documented to have “exit seeking/wandering” behaviors,” and two residents were identified as smokers. Of the 45 total residents at the facility, 22 residents resided in Lodge Two. Of the 22 residents, 8 residents required moderate assistance with ADL's and five had “exit seeking/wandering” behaviors.

The document key showed that residents with dementia/Alzheimer’s/cognitive impairment required additional staff time to assist the resident. The document indicated that residents who required moderate assistance would need standby assistance for transfers, ambulation, bathing and toileting and that for residents who required maximum assistance, a minimum of one to two caregivers were required to assist with all ADLs including assistance with turning, sitting up, and would require staff to turn the resident every two hours.

Record review of the facility's "Disclosure of Services" showed the facility maintained a smoke-free environment and the facility "will permit smoking in designated outside areas consistent with Initiative 901 as specified in the resident's negotiated service agreement. "

In an observation and interview on 03/27/2025 at 1:01 PM, Staff B, Director of Nursing, showed the department the resident smoking area located on the facility premises. The designated smoking area was outside of the resident accessible courtyard and up a small slope from Lodge One. Staff B stated that there were two residents who resided in Lodge One who smoked cigarettes, Resident 9 (R9) and Resident 10 (R10). Staff B stated that residents were only allowed to smoke when staff were available to escort them and stay with them while they smoked. Staff B acknowledged it was difficult to accommodate resident smoking requests when the facility was short staffed.

In an interview on 03/27/2025 at 3:10 PM, Collateral Contact 2 (CC2) stated the facility was understaffed consistently, including on day shift, where there was often only one medication technician on-shift to cover medication passes for all 45 residents. CC2 stated that residents that smoke often waited for prolonged periods of time due to low staffing.

In an interview on 03/27/2025 at 3:23 PM, Collateral Contact 1 (CC1) stated that residents who smoked had to wait a long time to smoke due to not having enough staff available to respond to the smokers' requests.

<Staffing>

In an interview on 03/27/2025 at 1:05 PM, Staff B stated that each lodge had two caregivers each and one medication technician that was shared by both lodges for day shift. Staff B stated that staffing for evening and night shift was one caregiver for each lodge and one medication technician who was shared by both lodges. Staff B stated that Staff C, Resident Care Coordinator (RCC), oversaw the staffing schedule. Staff B stated that Staff C often worked the shifts the facility was not able to get covered by staff and confirmed that Staff C had been working many floor staff shifts due to lack of staffing.

Record review of the staffing schedule for 03/21/2025 showed Staff C covered both day shift medication technician services and evening medication technician services. The schedule showed two open evening caregiving shifts.Record review of the staffing schedule for 03/22/2025 showed the day shift medication technicians covered the evening shift. The schedule showed an unfilled shift for an evening caregiving and an unfilled shift for a nightshift caregiver.

Record review of the staffing schedule for 03/23/2025 showed the day shift medication technicians covered the evening shift and that there was an unfilled evening caregiving shift. The schedule showed 2 of the 3-night shift staff called out sick. There was no scheduled medication technician on shift that night and only one caregiver on duty to care for all 45 residents between both buildings.Record review of the staffing schedule for 04/04/2025 showed there was only one medication technician and one caregiver scheduled to cover both buildings for night shift.

Record review of the staffing schedule for 04/05/2025 showed there was only one medication technician and one caregiver scheduled to cover both buildings for night shift.

Record review of the staffing schedule for 04/06/2025 showed there was only one medication technician and one caregiver scheduled to cover both buildings for night shift.

Record review of the staffing schedule for 04/11/2025 showed there was only one medication technician and one caregiver scheduled to cover both buildings for night shift.

Record review of the staffing schedule for 04/15/2025 showed there was only one medication technician and one caregiver scheduled to cover both buildings for night shift.

Record review of the staffing schedule for 04/16/2025 showed there was only one medication technician and one caregiver scheduled to cover both buildings for night shift.

<Resident 8>

Record review of R8's negotiated service agreement (NSA), 03/20/2025, showed they required total assist for toileting, ambulation, and transfers. The NSA also showed R8 was a fall risk and was up frequently at night requiring staff supervision and redirection.

Record review of the document titled "Washington Resident Assessment," dated 04/08/2024, showed R8 required 2-person assistance and additional time twice per week, required one-person total assistance with toileting, ambulation, and transfers.

Record review of the incident report, dated 03/20/2025, showed that at 8:15 AM R8 fell and hit their head while transferring themselves in and out of their bed unsupervised.

<Resident 7>
Record review of R7's "Washington Resident Assessment," dated 01/18/2024, showed R7 required 2-person assistance and additional time twice per week, one-person total assistance with toileting and dressing and had special care related to their suprapubic catheter(a rubber tube used to drain urine from the bladder to a bag located outside the body).

In an interview on 03/27/2025 at 1:15PM, Staff B stated that R7 pulled out their suprapubic catheter frequently and had just returned that day from the hospital for that same issue.

Record review of R7's undated NSA showed R7 required total assistance for toileting, ambulation, and transfers.

In an interview on 03/27/2025 at 1:42 PM, Staff B stated that their interpretation of maximum assist meant the resident needed at least one person to fully assist them for the required ADL.

In an interview on 03/27/2025 at 2:30 PM, Staff A, Executive Director, stated that NCNS meant no-call no-show. Staff A stated that when the staff calendar showed that information, it meant the shift was vacant.

In an interview on 03/27/2025 at 3:20 PM, Collateral Contact 1 (CC1), stated that there

were not enough staff on evening and night shifts and sometimes staff had to leave their assigned lodge to go over to the other lodge to assist residents.

In an observation on 03/27/2025 at 4:36 PM, the whiteboard in the executive director's office showed, “Open shifts for swing! (caregiving): -Thurs, Fri, Sat, Sun, -Tues, Thur, Fri,” and “Medtech Monday through Friday Lodge #2, Friday 3-11. “

In an interview on 03/27/2025 at 4:39PM, Staff B, Director of Nursing, stated that the facility was short staffed on evening shift and that the facility was short one medication technician for evening shifts every day. Staff B confirmed that the information on the whiteboard was current, and the shifts posted were still vacant.

In a interview on 04/16/2025 at 6:31 AM, Staff H, Caregiver, stated they were one of two staff that worked the night shift (shift started on 04/15/2025 and ended on 04/16/2025). Staff H stated there were approximately 3 residents that required 2-person assistance with care, but stated they were not sure which residents as they did not have access to updated and current care plans. When asked what staff do if there were only 2 total staff on shift and residents needed 2-person assistance, Staff H stated they would leave one building to go and assist the other caregiver, leaving one building unattended and unsupervised. Staff H stated they work on getting residents up, move them to the living room, then leave them unattended to assist the other building’s caregiver get residents up in the morning. Staff H reported this had been an ongoing issue, especially on Fridays, for the past three months since they started working at the facility. Staff H reported the night shift on Saturdays was also frequently only staffed with two staff to cover both buildings.

In an interview on 04/16/2025 at 3:41 PM, Staff A, Executive Director, and Staff B stated that night shift the staffing expectations were one caregiver in each building, and one medication technician shared between the two buildings (three total staff). Staff A and B stated that on 04/16/2025, 04/11/2025, 03/28/2025, and 03/21/2025 there was only one caregiver in each building and no other staff.

In an interview on 04/16/2025 at 3:57 PM, Staff G, Director of Operations, stated that two staff on night shift was not sufficient.

This is an uncorrected deficiency previously cited on 02/13/2025.

Statement of Deficiencies	License #: 2600	Compliance Determination # 56858
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 7 of 10	Licensee: Greenlake Management Lacey, LLC	04/18/2025

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) 5/30/25 .

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

Administrator (or Representative) 5/8/25 Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the facility failed to implement their policy and procedure for alert charting and failed to report an incident to the Complaint Resolution Unit for 1 of 1 resident (Resident 11 [R11]). This failure placed Resident 11 at risk for unmet care needs and decreased quality of life.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 02/13/2025, 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-2600] 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, Executive Director, signed the document on 03/02/2025. 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 03/19/2025."

Record review of the facility policy titled "Incident Investigation and Reporting," revised 02/15/2024, showed that all unusual occurrences should have an incident report

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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Record review of the facility policy titled “Incident Investigation and Reporting,” revised 02/15/2024, showed that all unusual occurrences should have an incident report

completed, including for all resident situations involving a resident, to include when property damage to the building occurred. The document showed the resident should be placed on alert charting and the facility would notify the family, physician and case manager, if applicable.

Record review of the facility document titled, “Assisted Living Facility Resident Characteristic Roster and Sample Selection,” undated, showed 45 residents resided in the two buildings (lodge 1 and Lodge 2) at the memory care facility. The document showed that all 45 residents had a diagnosis of [redacted], or [redacted]. Of the 45 residents, 23 residents resided in Lodge 1 and 22 residents resided in Lodge 1. Of the 23 residents in Lodge One, five residents were documented to have “exit seeking/wandering” behaviors. Of the 22 residents in lodge 2, five had “exit seeking/wandering” behaviors.The document showed R11 moved in on [redacted]/2025.

Record review of R11’s "Resident Face Sheet," dated 03/22/2025, showed R11 had a guardian that was listed as R11’s only personal contact on file.

On 03/27/2025 at 1:00PM, Staff B, Director of Nursing, provided a tour of the facility, including the shared courtyard between the two lodges. Staff B explained that residents were allowed to enter the shared courtyard whenever they chose and that there was no way to monitor residents when they were in the courtyard. Staff B also stated that the only way staff were alerted that a resident entered the courtyard was a single dinging sound when the door initially opened.

In an interview on 03/27/2025 at 1:05 PM, Staff B stated that each lodge had two caregivers each and one medication technician that was shared by both lodges for day shift. Staff B stated that staffing for evening and night shift was one caregiver for each lodge and one medication technician who was shared by both lodges. Staff B stated that the medication technician would use the shared courtyard to go between the two lodges.

In an interview on 03/27/2025 at 1:10 PM, Staff B stated that the staff expectation for resident supervision was that staff view each resident at least once every two hours.

In an interview on 03/27/2025 at 3:19 PM, Collateral Contact 1 (CC1), stated that R11 rippedoff some of the fence in the outside, resident courtyard.CC1 stated that there were not enough staff on evening and night shifts and sometimes staff must leave their assigned lodge to go over to the other lodge to assist residents.

In an interview and observation on 03/27/2025 at 3:25 PM, new fence boards were seen in the outside, resident courtyard. CC1 confirmed those boards were new and used to replace the board pieces that R11 had pulled off the day prior.

Record review of the facility incident log showed the incident involving R11 ripping off the outside courtyard fence was not documented as a facility incident.

In an interview on 03/27/2025 at 4:13PM, Staff A, Executive Director, confirmed that the incident involving R11 resulted in the replacement of fence boards at the facility. Staff A stated that the incident occurred the day prior, on 03/26/2025 and stated that the incident was not investigated as an unusual occurrence, nor was it reported to the Complaint Resolution Unit.

In an interview on 03/27/2025 at 4:15PM, Staff B confirmed R11 did rip off part of the fence in the resident courtyard in an attempt to leave the premises, but that it was not included on the incident log because the facility did not classify R11 removing part of the fence in an attempt to leave the facility as an incident. Staff B stated they did not include the incident on the incident log because residents tried to leave the facility "all the time." Staff B did confirm that other residents did not successfully remove parts of the fence at the same frequency.

On 03/27/2025 at 4:30PM, R11's progress notes for 03/19/2025 through 03/27/2025, any and all incidents for R11 within that timeframe, and R11's negotiated service agreement were requested.

In an interview on 03/28/2025 at 2:57 PM, Staff B stated that if there were no notes for a specific day in a resident chart, then no notes were documented for that resident on that date. Staff B stated they would provide the remaining documents the department requested as soon as possible.

On 3/28/2025 at 4:43 PM, Staff B emailed the progress note log for R11.

Record review of R11's progress notes for dates 03/19/2025 through 03/28/2025, showed two notes entered.

-The first note was created by Staff F, Medication Technician, on 03/26/2025 at 3:45PM and said " At approximately 1:50PM, the resident knocked down the fence because [they] wanted to go back home in Chicago, the resident made it out of the building and of the med techs caught [them] walking outside the building and [the med tech] redirected [them] back in the lodge. The maintenance person was notified about the fence and acted right away to fixing the fence back. Director of nursing notified of the incident and ED [Executive Director] as well." The note category was "Behavior."

-The second note was created 03/28/2025 at 4:02 PM by Staff A. The note said "Staff reported that resident had pulled a fence board off and was in the courtyard, attempting to leave for Chicago, the fence board was put back on. The other side of the gate remained intact with no way to exit through the gate as it was also locked." The

Statement of Deficiencies	License #: 2600	Compliance Determination # 56858
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note category was "ED note."

There were no other notes, nor incident investigations for review for R11. The documentation did not show that alert charting was initiated, nor that a report to Complaint Resolution Unit was made. The documentation also did not show that R11's guardian was notified of the incident.

Record review of the Department's data base on 04/10/2025, showed the incident had not been reported to the Department for the incident of R11 removing the fence board and leaving the enclosed area on 03/26/2025.

In an interview on 04/11/2025 at 11:00 AM, Staff A, Staff B and Staff G, Corporate Director of Operations, acknowledged the deficiency.

This is an uncorrected deficiency previously cited on 02/13/2025.

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) 5/30/25.

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

Administrator (or Representative) 5/5/25 Date

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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: 159726
Compliance Determination #: 52461
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 01/02/2025 through 02/13/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Report of concerns related to staffing.
2. Pharmaceutical Services: Report of a medication error.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 10 Closed records sample size: 1
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication administration Kitchen
Interviews:	Nursing staff Residents Housekeeping staff Executive Director
Record Reviews:	State reporting log Facility policies Care Plans Progress noes MAR Staff Working Schedules

Investigation Summary:

1. Record review and interview showed incidents occurred resulting in a lodge being left unattended. Failed practice identified.
2. Facility failed to monitor residents after a medication error was discovered. Failed practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2600
Intake ID: 159816
Compliance Determination #: 52461
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 01/02/2025 through 02/13/2025
Complainant Contact Date(s):

Allegation(s):

1. Physical Environment: Report of facility running out of supplies and not having supplies to keep rooms and bathrooms clean.
2. Quality of Care/Treatment: Report of resident hitting other residents for the past year.
3. Administration/Personnel: Report of facility being short staffed resulting in not being able to care for residents.

Investigation Methods:

Sample:
Total residents: 51
Resident sample size: 10
Closed records sample size: 1

Observations:
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration
Kitchen

Interviews:
Nursing staff
Residents
Housekeeping staff
Executive Director

Record Reviews:
State reporting log
Facility policies
Care Plans
Progress noes
MAR
Staff Working Schedules

Investigation Summary:

1. Facility staff state they have run out of supplies. Staff purchased the supplies that

were needed that day. Unable to substantiate failed practice.
2. Staff interviewed unable to confirm anyone hitting others. Unable to substantiate failed practice.
3. Record review and interview showed incidents occurred resulting in a lodge being left unattended and staff expressing concerns related to staffing. Failed practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2600
Intake ID: 158372
Compliance Determination #: 52461
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 01/02/2025 through 02/13/2025
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Public concern of the environment of the facility and staffing.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 10 Closed records sample size: 1
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication administration Kitchen
Interviews:	Nursing staff Residents Housekeeping staff Executive Director
Record Reviews:	State reporting log Facility policies Care Plans Progress noes MAR Staff Working Schedules

Investigation Summary:
Facility environment did not have foul odors, no residents noted to have odors, kitchen did not appear to be unsanitary or have odor. Facility has process in place for staff to follow regarding removing garbage from the facility. Unable to substantiate failed practice. Record review and interview showed incidents occurred resulting in a lodge being left unattended and staff expressing concerns related to

staffing. Failed practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2600
Intake ID: 159445
Compliance Determination #: 52461
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 01/02/2025 through 02/13/2025
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Report of staff unable to care for staff due to low staffing.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 10 Closed records sample size: 1
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication administration Kitchen
Interviews:	Nursing staff Residents Housekeeping staff Executive Director
Record Reviews:	State reporting log Facility policies Care Plans Progress noes MAR Staff Working Schedules

Investigation Summary:
1. Record review and interview showed incidents occurred resulting in a lodge being left unattended and staff report concerns related to staffing. Failed practice identified.

Conclusion / Action:

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

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

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 01/02/2025 and 02/13/2025 of:

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

This document references the following complaint number(s): 159726, 159816, 158372, 159445

The following sample was selected for review during the unannounced on-site visit: 10 of 51 current residents and 1 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.

Jody Just
Residential Care Services

02/20/2025
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

3.2.25
Date

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

(b) Maintain the assisted living facility free of safety hazards; and

(c) Implement fire and disaster plans.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure they had sufficient staff to meet resident needs for 2 of 2 memory care units reviewed. This failure resulted in the memory care unit being left unattended during an incident while providing resident care and placed all 51 of 51 residents at risk for unmet care needs and safety concerns.

Findings included...

Record review of Department of Social and Health Services Dear Provider Letter, dated 10/31/2024, showed "the purpose of this letter is to remind providers and facilities when it is appropriate for facilities to call emergency medical services (EMS) or 911...As you may know, emergency departments have reached record high wait times and EMS crews are becoming increasingly overburdened. The unintended consequences of these statistics can result in negative resident outcomes. We encourage each facility to be proactive in planning each resident/clients care and explore resources that can help support the residents/clients and community. This can include reviewing and implementing:

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 _____

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Findings included…

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-Resident/client goals for treatment, advanced directives, and specifics listed on the physician orders for Life-Sustaining Treatment (POLST)form.
-Use of mobile x-ray, onsite urgent care, physician consult/visits, etc.
-EMS usage in policies, procedures, and long-standing practices.
-Best practices for before, during, and after a resident/client-focused 911 call; and
-Expectations to best serve resident/clients, staff, EMS, hospitals, and community resources
Please review relevant state laws and rules pertaining to your responsibilities related to resident/clients, their medical issues, and the use of the local fire department and emergency medical services (EMS) or 911. Please remember that you are required to have sufficient and trained staff, equipment, and supplies at all times to respond to resident/client needs, including medical emergencies.

The staff must be capable of:

-Evaluating the resident/clients condition ongoing:
-Assisting the resident/client back to the pre-fall position if there are no signs of injuries; and
-Providing the EMS team with sufficient information on the resident's condition and observed acute changes when making the 911 call and upon arrival of the EMS
LTC [Long Term Care] facilities are encouraged to:
-utilize alternatives to an ER [Emergency Room] visit, such as mobile x-ray, onsite urgent care, or physician consult/visits, etc
-Use the guidance and educate staff and residents for when EMS is called, included in the Dear Provider Letter
-Be proactive when identifying, meeting, and addressing medical and mental health needs.
Please note that the EMS team can independently determine whether or not the transfer to the hospital is appropriate depending on their evaluation of the resident and/or medical information presented to them by facility staff. This can result in a possible denial to transfer the resident to the hospital if they feel it is not medically necessary, and the resident is stable. Facility staff are not required to have EMS sign a document stating they are denying the transfer. Instead, a written statement in the resident record is sufficient.

EXAMPLES WHEN TO CALL 9-1-1:
- Has an acute/serious, life-threatening medical condition or complaint. A medical emergency can be defined as something that will result in loss of life or limb if not treated immediately.
-Is medically unstable; or
-Has an immediate health risk.
-Examples can include:
- Head injury with change of mental status.
-Large burn or cut that will not stop bleeding.
-Trouble breathing- unable to speak in full sentences; or
-First time or longer than normal seizure.
EXAMPLES WHEN NOT TO CALL 9-1-1:

-The resident/client is medically stable.
-Health status is non-acute or not serious.
-Fall that did not result in obvious injury or mental status change.
-Need of medication or supplies that the facility is required to have/complete on site.
This letter does not mean that you should never call 9-1-1. When your evaluation or assessment of the resident shows that the resident may have a medical emergency, you should call 9-1-1. Please refer to the guidance below when calling 9-1-1."

Review of Department records showed that a report was made on 01/18/2025 at 1:10 PM notifying the Department of low staffing concerns.

Review of Department records showed that a report was made on 12/19/2024 at 9:42 AM notifying the Department the "facility keeps the workers short staffed."

Review of Department records showed that a report was made on 12/09/2024 at 4:07 PM notifying the Department of low staffing concerns.

Review of Department records showed that a report was made on 12/16/2024 at 3:30 PM notifying the Department that they facility is short staffed on evening shift and NOC (nighttime caregiver) shift and there are "a lot of falls due to short staffing."

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection," undated, showed 28 residents resided in the Lodge 1 memory care unit. Of those 28 residents, 5 required maximum assistance and 10 required moderate assistance with ADL's (Activities of Daily Living). Of those 28 residents in Lodge 1, 28 residents were documented to have "dementia/Alzheimer's/ cognitive impairment." (Dementia is a general term that describes a group of symptoms that affect cognitive function, memory, language, and behavior and Alzheimer's is a disease in the brain, whereas dementia is a collection of symptoms). Of those 28 residents in Lodge 1, 6 were documented to have "exit seeking/wandering" behaviors.

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection," undated, showed 21 residents resided in the Lodge 2 memory care unit. Of those 28 residents, 5 residents required maximum assistance, and 10 residents required moderate assistance with ADL's (Activities of Daily Living). Of those 28 residents in Lodge 1, 28 were documented to have "dementia/Alzheimer's/ cognitive impairment." (Dementia is a general term that describes a group of symptoms that affect cognitive function, memory, language, and behavior and Alzheimer's is a disease in the brain, whereas dementia is a collection of symptoms). Of those 28 residents in Lodge 1, 6 were documented to have "exit seeking/wandering" behaviors.

In an interview on 01/02/2025 at 10:10 AM, Staff C, Caregiver, stated they have been short staffed at the facility. Staff C stated they know NOC shift is suffering. They stated

they are not fully staffed and that a lot of the times it is just one med tech and one caregiver on shift for both buildings.

In an interview on 01/02/2025 at 10:21 AM, Staff D, Med tech, was asked if they had any concerns with staffing and they stated yes, we are trying the best we can. Staff D stated another caregiver is out on L and I (Labor and Industries) due to an injury they sustained caring for R5, and they are running around like crazy due to short staffing. Staff D stated R5 has since passed away.

In an interview on 02/07/2025 at 1:54 PM, Staff B was asked what the working hours for each shift are, they stated day shift is from 7:00 AM-3:00 PM, Evening shift 3:00 PM-11:00 PM and NOC shift is 11:00 PM-7:00 AM.

Record review of R5's face sheet, dated 12/17/2024, showed that R5 admitted to the facility on [redacted]/2024.

Review of R5's Needs and Services Plan (Facility's version of the Negotiated Service Agreement), last reviewed on 12/01/2024, under the "Toileting" category stated, "Due to RSD (resident) decline, staff will assist with ADL (activities of daily living) tasks. [R5] requires total assistance with incontinent care" Under the section titled, "Transfers," showed, R5 is a 2 person assist. R5 is unable to self-transfer, they require the assistance with a mechanical lift to transfer.

Record review of R5's progress notes, date range 10/29/2024 through 12/24/2024 and November working schedule, showed the following:

-an entry on 10/29/2024 at 11:54 PM (NOC shift), showed R5 was very restless and kept walking into other resident rooms. Staff tried to help the resident to bed and when resident became combative, the resident choked the Med Tech around their neck and pulled Med techs hair back. R5 began throwing dining room chairs around. R5 pulled out a sharp stick and held it in their hands.

-an entry on 11/09/2024 at 2:14 AM (NOC shift), showed R5 got up before shift change and refused to lay back down. R5 was encouraged to sit in a recliner where he relaxed. R5 stated they were ready to go to bed so Med Tech laid R5 down. "When med tech returned to Lodge around 1:30 resident was naked in the hallway. Resident was redressed by staff but got naked again."

Record review of November 2024 NOC schedule on 11/08/2024, undated, showed 2 staff were scheduled on NOC shift to cover both buildings.

-an entry on 11/10/2024 at 10:34 PM (NOC shift), showed R5 was aggressive with staff

at dress change. R5 refused to follow directions in changing their briefs and was being very difficult to redirect. R5 charged at staff and fellow residents with his walker and raised his arms in an angry roar fashion. R5 got angrier and wanted to pick fights for no reason.

Record review of November 2024 NOC schedule on 11/10/2024, showed 2 staff scheduled on NOC shift to cover both buildings.

-an entry on 11/14/2024 at 12:30 AM (NOC shift), showed R5 was found lying on the floor at 11:30PM. Caregiver notified Staff B that R5 was on the floor. Staff B assisted R5 back into bed.

Record review of November 2024 NOC schedule on 11/13/2024, showed 2 staff were scheduled on NOC shift to cover both buildings.

-an entry on 11/21/2024 at 3:40 AM (NOC shift), showed, Shortly after 1:00AM, med tech was “heading to Lodge 2” and could hear yelling. Med tech arrived to R5’s room where R5 was discovered to be on the floor. Several attempts were made to get R5 up. 911 was called and R5 was taken to the hospital.

Record review of November 2024 NOC schedule on 11/20/2024, showed 2 staff were scheduled on NOC shift to cover both buildings.

-an entry on 11/22/2024 at 10:17 PM, R5 being sent out due to fall in which resident stated he hit his head.

Record review of November 2024 NOC schedule on 11/22/2024, showed 3 staff were scheduled on NOC shift to cover both buildings.

-an entry on 11/23/2024 at 3:46 AM (NOC shift), showed R5 is still at the hospital for fall. Hospital called and did highly recommend that R5 be watched as closely as possible to decrease any more falls.

-an entry on 11/24/2024 at 6:51 AM, showed R5 is unable to bear weight. R5 “continues to use hoyer” lift (a mechanical device to transfer a person) for transfers.

Record review of November 2024 NOC schedule on 11/23/2024, showed 2 staff were scheduled on NOC shift to cover both buildings.

-an entry on 12/07/2024 at 10:00 PM showed R5 was too weak to stand up. Care staff

laid him on a mattress on ground per new care plan. Care staff had to use hoyer as resident could not bear weight.

Record review of December 2024 NOC schedule on 12/07/2024, showed 2 staff were scheduled on NOC shift to cover both buildings.

-an entry on 12/13/2024 at 12:00 AM, showed “Late Entry- at about 0445 in the morning as this med tech was doing the morning checks it was observed that the resident had fallen out of bed. upon further checking the resident out it was noted the resident had a small bruise left eyebrow…The two caregivers and this med tech were able to safely use the hoyer the resident back into bed.”

Record review of December 2024 NOC schedule on 12/11/2024, showed 2 staff were scheduled on NOC shift to cover both buildings.

Record review of December 2024 NOC schedule on 12/12/2024, showed 2 staff were scheduled on NOC shift to cover both buildings and one person in training.

Record review of R6’s face sheet, dated 01/17/2025, showed that R6 was admitted to the facility on [redacted]/2024.

Record review of R6’s incident report, dated 11/16/2024 at 4:00 AM, showed R6 was up walking in the dining room, they went back into their apartment, and they lost their balance and fell. R6 injured their right hip and was taken to the hospital.

Record review of R6’s progress notes dated 11/16/2024 for last 90 days, and November working schedule, showed the following:

-an entry on 11/16/2024 at 8:40 AM showed R6 was up early in the morning around 4 AM. They were walking around the dining room. R6 came by the med tech office and stated hi. R6 left and went back to their apartment. A few minutes later the caregiver who was on duty came to the med tech and told them that the resident had fallen, and they got themself up. “He was in so much pain on his right hip.” R6 was screaming in pain and 911 was called and he was taken to the hospital.”

Record review of November 2024 NOC schedule on 11/15/2024, showed 2 staff were scheduled on NOC shift to cover both buildings.

In an interview on 02/06/2025 at 10:23 AM, Staff A was asked to explain what happened according to the incident report, they stated they can’t find it. Staff A was asked to explain what happened according to the progress notes. They stated that the incident

occurred on 11/16/2024 at 4:00 AM. Staff A was asked if the med tech and the caregiver were in the same building, they stated they assumed, but they would have to look at the schedule. Staff A was asked who was working NOC shift on 11/15/2024, they stated Staff H and Staff J.

Record review of the November NOC schedule showed:
-11/03/2024 NOC shift only 1 staff member working to cover both buildings
-11/04/2024 NOC shift no staff scheduled
-11/05/2024 NOC shift only 1 staff member working to cover both buildings.

Record review of the December NOC schedule showed:
-12/01/2024-12/09/2024: 2 staff members scheduled to cover both buildings
-12/11/2024: 2 staff members scheduled to cover both buildings
-12/15/2024: 2 staff members scheduled to cover both buildings
-12/22/2024: 2 staff members scheduled to cover both buildings

In an interview on 01/02/2025 at 10:38 Staff D stated, “when we come on shift there is just a med tech in Lodge 1 and a caregiver in Lodge 2. All shifts are short staffed. Christmas was bad. We had two falls back-to-back. We are still coming into wet beds, residents are soaked.”

In an interview on 01/02/2025 at 11:11 AM, Staff E, Caregiver, stated “we have residents who use a hoyer and we have to check them and feed them. We are short staffed. A lot of times there is just a med tech and aid for both buildings on NOC shift.”

In an interview on 01/02/25 at 11:25 AM, Staff F, Med Tech, stated they were short staffed and there are issues with staffing.

In an interview on 01/17/2024 at 12:40 AM, Staff G, caregiver, was asked what the process was when they need to provide care to a resident who is a 2 person assist, they stated they will ask whoever is next door to come help. Staff G was asked what if there was only one other person working, they stated, then they come over and help me. Staff G stated I don’t provide care to a person who needs 2-person assistance. Staff G was asked if the other building is left unattended, they stated yes. Staff G was asked if there are any residents who try to leave the building, they stated there is a resident who likes to walk in between the buildings at night. Staff G stated when they get out, we try to keep an eye on them, they takes their nightly stroll. Staff G was asked if that resident goes outside every night, they stated yes, most nights. Staff G was asked if they go outside to watch them, they stated, yes, they will check on them. Staff G stated they have never seen the resident climb a fence, but they state they do want to leave. Staff G was asked when they go outside to check on the resident if there was any other staff in the building, they stated no.

In an observation on 01/17/2025 at 12:29 AM, three residents were observed sitting in

the living room, the TV was on, one resident watching TV and 2 residents asleep.

In an interview on 01/17/2025 at 1:05 AM, Staff H, Caregiver, was asked if there were any residents that are two-person care, they stated yes, R7. Staff H was asked what they do when they need a second person to assist with care, they stated they will get the med tech or the other caregiver from the other building because sometimes there's only two people working. Staff H was asked when they call someone over to help them, if the other building is left unattended, they stated, yes. Staff H stated they have had to call the fire department out before to help get R7 off of the floor.

Record review of R7's face sheet, dated 12/17/2024, showed that R7 was admitted to the facility on [redacted]/2023.

Review of R7's Needs and Services Plan (Facility's version of the Negotiated Service Agreement), last reviewed on 04/19/2023, under the "Toileting" category stated, "Total Assist". R7 has urinary incontinence and may need staff assistance to change undergarments when soiled; they may not recognize that their clothing is wet or soiled. They may be incontinent of bowel. They need assistance to change undergarments if they have bowel incontinence.

In an observation and interview on 01/17/2024 at 1:50 AM, Staff H and Staff I, caregiver in training, went into R7's room to provide care to R7. Staff I instructed R7 to "roll" so that the briefs could be changed. R7 did not comply. Staff H stated, R7 might be a two person assist to change.

In an interview on 2/05/2025 at 4:25 PM, Staff A was asked what staffing was like for NOC shift, they stated typical staffing was a caregiver in each Lodge and a med tech that floats in between the two buildings. Staff A was asked where residents could be at nighttime, they stated they could be in their rooms, some prefer to sleep in the living room, or they are awake in the living room. Staff A was asked if residents wander at night, they stated yes inside the building, they could be up all hours of the night. Staff A was asked it possible for a fall or even a resident-to-resident altercation to happen in the living room at night, they stated it is a possibility. Staff A was asked what the process was for the caregiver if there was a fall or an altercation in their Lodge, they stated if there was a fall with injury, they are to call the med tech to come help them, the med tech would call 911. Staff A was asked if the caregiver would call the med tech for help if there was an altercation, they stated yes that is the expectation. Staff A was asked if there had been times where only one person was scheduled to work in Lodge 1 and there was one person scheduled to work in Lodge 2, they stated I don't know specifically but I know there has been. I would assume it has happened. Staff A was asked if it is ever acceptable to leave the Lodge unattended, they stated no.

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) 3/19/25 .

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

RM
Administrator (or Representative)

3.20.25
Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement their policies and procedures for alert charting after an incident occurred for 3 of 3 residents (Resident 1[R1], Resident 2[R2] and Resident 3 [R3]). The facility also failed to notify the Complaint Resolution Unit for two incidents that occurred for 1 of 1 resident (Resident 4 [R4]) when an incident occurred. These failures placed 51 of 51residents at risk for unidentified care needs and a decreased quality of life.

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 facility policy, titled, "Abuse and Neglect-Resident," dated 02/15/2024, showed, "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." Under the section, titled, "Reporting witnessed or suspected abuse or neglect," showed, "The alleged abuse will be immediately reported by the person who witnessed it, to the supervisor on duty, or the Administrator, and to the

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

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Based on interview and record review, the facility failed to implement their policies and procedures for alert charting after an incident occurred for 3 of 3 residents (Resident 1[R1], Resident 2[R2] and Resident 3 [R3]). The facility also failed to notify the Complaint Resolution Unit for two incidents that occurred for 1 of 1 resident (Resident 4 [R4]) when an incident occurred. These failures placed 51 of 51residents at risk for unidentified care needs and a decreased quality of life.

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appropriate state agency, following the guidelines for mandatory reporting."

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, "Alert Charting," dated 02/15/2024, stated, "Alert charting will be implemented when a resident's condition requires increased monitoring and observation for a limited period of time until the condition is resolved in accordance with WAC 388-78A-2120. Under the section titled, "Procedure" showed, "Each Licensed Nurse or shift supervisor is responsible for initiated alert charting and maintaining it for a period of at least 72 hours, when a resident presents with a condition listed below. The Health Services Director is accountable for ensuring the documentation occurs and the Primary Care Provider is notified if indicated."

<Alert Charting>

Record review of a report to the department on 12/18/2024 at 1:10 PM, showed a report of multiple residents receiving double their medications (twice the dose) of their morning doses.

<R1>

Record review of R1's face sheet, dated 01/02/2024, showed that R1 was admitted to the facility on [redacted]/2024.

Record review of the facility provided document (Temporary Service Plan), untitled and undated, showed R1 was on alert due to a medication error. Listed were possible side effects to be aware of. Start date showed 12/15/2024. End date showed 12/21/2024. Document signed by the Resident Care Coordinator, Health Services Director, and Executive Director on 12/18/2024. On the bottom of the document showed, "Notes: Vitals on each shift. Alert charting on each shift."

Review of R1's progress notes date range from 12/11/2024 through 12/30/2024 showed:

-an entry on 12/18/2024 at 2:45 PM showed that R1 was on alert for med error, R1 took two dosages of Levothyroxine (a medication used to treat hypothyroidism, a condition where the thyroid gland does not produce enough thyroid hormone.) Will continue to monitor them. Vitals taken.

-an entry on 12/18/2024 at 9:29 PM, showed R1 was on alert for med error. R1 took two dosages of Levothyroxine. Vitals taken.

-No entry for alert charting was completed on 12/19/2024 to monitor resident's condition.

-No entry for alert charting was completed on 12/20/2024 to monitor resident's condition.

-No entry for alert charting was completed on 12/21/2024 to monitor resident's condition.

<R2>

Record review of R2's face sheet, dated 01/15/2025, showed that R2 was admitted to the facility on [redacted]/2015.

Record review of the facility provided document (Temporary Service Plan), untitled and undated, showed R2 was on alert due to a medication error. Listed were possible side effects to be aware of. Start date showed 12/18/2024. End date showed 12/21/2024. Document signed by the Resident Care Coordinator, Health Services Director, and Executive Director on 12/18/2024. On the bottom of the document showed, "Notes: Vitals on each shift. Alert charting on each shift."

Review of R2's progress notes date range from showed:

-an entry on 12/18/2024 at 2:25 PM showed that R2 was on alert for med error. R2 took double dosage of Levothyroxine, Aspirin (Aspirin is in a group of medications called salicylates. It works by stopping the production of certain natural substances that cause fever, pain, swelling, and blood clots), and Omeprazole (used to treat frequent heartburn (heartburn that occurs at least 2 or more days a week) in adults. Omeprazole is in a class of medications called proton-pump inhibitors. It works by decreasing the amount of acid made in the stomach.) Will continue to monitor them. Vitals taken.

-an entry on 12/18/2024 at 9:26 PM, showed R2 was on alert for med error. R2 took double dosage of Levothyroxine, Aspirin and Omeprazole Will continue to monitor them. Vitals taken.

-No entry for alert charting was completed on 12/19/2024 to monitor resident's condition.

-No entry for alert charting was completed on 12/20/2024 to monitor resident's condition.

-No entry for alert charting was completed on 12/21/2024 to monitor resident's condition.

<R3>

Record review of R3's face sheet, dated 01/02/2025, showed that R3 was admitted to the facility on [redacted]/2022.

Record review of the facility provided document (Temporary Service Plan), untitled and undated, showed R3 was on alert due to a medication error. Listed were possible side effects to be aware of. Start date showed 12/15/2024. End date showed 12/21/2024. Document signed by the Resident Care Coordinator, Health Services Director, and Executive Director on 12/18/2024. On the bottom of the document showed, "Notes: Vitals on each shift. Alert charting on each shift."

Review of R3's progress notes showed:

-an entry on 12/18/2024 at 2:48 PM showed that R3 was on alert for med error. R3 took double dosage of Levothyroxine. Will continue to monitor them. Vitals taken.

-an entry on 12/18/2024 at 9:31 PM, showed R2 was on alert for med error. R2 took double dosage of Levothyroxine. Will continue to monitor them. No vitals taken.

-No entry for alert charting was completed on 12/19/2024 to monitor resident's condition.

-No entry for alert charting was completed on 12/20/2024 to monitor resident's condition.

-No entry for alert charting was completed on 12/21/2024 to monitor resident's condition.
In an interview on 01/02/2025 at 1:22PM, Staff A, Executive Director, was asked what was done for the residents after the medication error was discovered, they stated they were put on alert.
In an interview on 01/02/2025 at 1:50PM, Staff B, Health Services Director, was asked what was done after the medication error occurred, they stated the residents were put on alert, the PCP (Primary Care Provider) was notified, and staff were told what side

effects to be aware of due to being over dosed.
In an interview on 01/02/2025 at 2:46PM, Staff B stated the residents would go on alert charting for three days. The med techs would chart each shift for at least three days minimum. Staff B was asked what they would be monitoring for, they stated, the side effects of the medications listed on the TSP (Temporary Service Plan).

<Notification to the Complaint Resolution Unit>

Record review of R4's face sheet, dated 01/17/2025, showed that R4 was admitted to the facility on [redacted]2024.

Review of R4's last 30 days of progress notes, dated 01/17/2025, showed.

-an entry on 01/02/2025 at 7:21 AM, showed a male resident was found in R4's room. The male resident was caught putting his penis in R4's face. Caregiver apologized to the female resident and continued to check on R4 throughout the remainder of the night

-an entry on 01/15/2025 at 11:11 AM, showed that the caregiver on duty reported to the medication technician that there was an altercation between R4 and another resident. R4 slapped the other resident in the face.

Record review of the Departments data base on 02/07/2025, showed the incident had not been reported to the Department for the incidents between R4 and the other resident for the incident on 01/02/2025.

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) 3/19/25 .

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

Administrator (or Representative) — 3.2.25 Date

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

_____ _____
Administrator (or Representative) Date

Greenlake SENIOR LIVING

Plan of Correction

Agency Name	Citation Date
Memory Care at the Lodges #2600	02/13/25
Submitted By	**Date of POC Submission**
Rebecca Kinsley	03/07/25
	Compliance Date
☑ **Complaint Citation** ☐ **Certification Citation**	03/19/25

Citation: WAC 388-78A-2600 Policies and Procedures	
What *initial* or *immediate actions* were taken to address concerns affecting clients?	Review of RCW 74.24.035 with Management team. Training and In services completed on RCW, Alert monitoring policy, documentation, expectation, HSD follow up. Review of Self reportable events, refer to ALF guidebook, self reporting if in doubt
How will you apply the correction to all clients you support?	HSD to monitor alert monitoring over the weekends x6 weeks or until he is confident staff have a clear understanding of expectations and good trend on documentation, then will change to as needed auditing. All incidents to be rolled up to Director of Operations, depending on incident, ED will ensure all reportable events are submitted to DSHS within 24 hrs, DO will follow up with all documentation and have ready for inspection.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	HSD for all alert monitoring, incident reports an closure ED for all reportable events, including having all documentation ready for RCS when they follow up DO will work directly with team for all incidents until I feel comfortable that the team is headed in the right direction following GSL P&P and is compliant with WA regs.
Additional Information:	
In-Service/Training:	Attach all in-service training sheets and receipts for completion.

Completion Date:	**Completion Date:**	**Completion Date:**	**Completion Date:**
3/6/25			

Plan of Correction Policies:

1. When the **Statement of Deficiencies** form is received from the State, **Plan of Correction** form(s) are to be completed for each WAC violation with a plan for completion dates and training dates.
2. Once completed, email **Statement of Deficiencies** with the **Plan of Correction** form(s) to VP of Operations, Regional Operations Director, and Clinical Director.

Executive Director Name: Rebecca Kinsley Signature: _____ Date: 3/7/25

Greenlake SENIOR LIVING

Plan of Correction

Agency Name	Citation Date
Lacey Memory Care at the Lodges	02/13/25
Submitted By	**Date of POC Submission**
Rebecca Kinsley	03/07/25
	Compliance Date
☑ **Complaint Citation** ☐ **Certification Citation**	03/19/25

Citation: WAC 388-78A-2450 Staff	
What *initial* or *immediate actions* were taken to address concerns affecting clients?	Review of Clinical coverage in both cottages. Instructed Management team to ensure there is no less than 1 Med tech, 2 caregivers on NOC shift, and 2 med techs and 4 caregivers on Swing shift, and 1 MT and 4 caregivers on day shift. All management will have employee roster with contact info to aid in finding coverage.
How will you apply the correction to all clients you support?	As above. Hiring new credentialed team members will aid in appropriate shift coverage. In service will be completed on call outs and shift coverage; ie: who is responsible to cover, what coverage looks like, hiring needs and importance of continuous teaching and training.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Executive Director and Health Services Director will monitor and oversee staffing. Resident Care Coordinator will review indeed ads, continue to interview and make changes to the clinical staffing schedule as needed.
Additional Information:	Hiring will be continuous, approvals will be directed to the ED for certified and qualified new hires.
In-Service/Training:	Attach all in-service training sheets and receipts for completion.

Completion Date:	Completion Date:	Completion Date:	Completion Date:
3·06·25			

Plan of Correction Policies:

1. When the **Statement of Deficiencies** form is received from the State, **Plan of Correction** form(s) are to be completed for each WAC violation with a plan for completion dates and training dates.
2. Once completed, email **Statement of Deficiencies** with the **Plan of Correction** form(s) to VP of Operations, Regional Operations Director, and Clinical Director.

Executive Director Name: Rebecca Kinsley Signature: _____ Date: 3·7·25