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

05/22/2025

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) 59784 (Completion Date 05/22/2025) and 55370 (Completion Date 03/07/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/22/2025 and found no deficiencies.

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

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

WAC 388-78A-3140 Responsibilities during inspections. The assisted living facility must:

(2) Provide requested records to the representatives of the department; and

The Department staff who did the On Site verification:
Paul Aube, ALF NCI

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2600
Intake ID: 165100
Compliance Determination #: 55370
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 02/26/2025 through 03/07/2025
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Facility Report of a resident-to-resident altercation in the community.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members Kitchen staff Laundry staff Management
Record Reviews:	Medical records Facility policies Incident investigation Negotiated Service Agreements Medication Administration Records Progress Notes/Alert Charting Hospital Records

Investigation Summary:
Quality of Care/Treatment: Facility failed to monitor residents, and failed to follow policies and procedures after incident occurred in the community. Regarding monitoring of residents, these issues were addressed under Statement of Deficiencies dated 11/18/2024. Regarding policies and procedures, these issues were addressed under Statement of Deficiencies dated 02/13/2025. Facility is in their plan of correction phase to address non compliance. The facility also failed to

provide documentation, as requested by the department, during an investigation. 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: 168186
Compliance Determination #: 55370
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 02/26/2025 through 03/07/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Public report of facility failing to obtain and provide medications, resulting in resident hospitalization.
2. Nursing Services: Public report of facility failing to obtain and provide medications, resulting in resident hospitalization.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members Kitchen staff Laundry staff Management
Record Reviews:	Medical records Facility policies Incident investigation Negotiated Service Agreements Medication Administration Records Progress Notes/Alert Charting Hospital Records

Investigation Summary:

1. Quality of Care/Treatment: Facility failed to obtain, and administer resident medications as ordered by their provider. This failure resulted in residents being hospitalized. Failed practice Identified.
2. Nursing Services: Facility failed to obtain, and administer resident medications as

ordered by their provider. This failure resulted in residents being hospitalized. 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: 168010
Compliance Determination #: 55370
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 02/26/2025 through 03/07/2025
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Facility Report of a resident-to-resident altercation in the community.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members Kitchen staff Laundry staff Management
Record Reviews:	Medical records Facility policies Incident investigation Negotiated Service Agreements Medication Administration Records Progress Notes/Alert Charting Hospital Records

Investigation Summary:
Quality of Care/Treatment: Facility failed to monitor residents, and failed to follow policies and procedures after incident occurred in the community. Regarding monitoring of residents, these issues were addressed under Statement of Deficiencies dated 11/18/2024. Regarding policies and procedures, these issues were addressed under Statement of Deficiencies dated 02/13/2025. Facility is in their plan of correction phase to address non compliance. The facility also failed to

provide documentation, as requested by the department, during an investigation. 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 02/26/2025 and 02/27/2025 of:

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

This document references the following complaint number(s): 165100, 168186, 168309, 168010

The following sample was selected for review during the unannounced on-site visit: 5 of 51 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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

03/18/2025
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)

Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs - Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to implement safe medication practices to ensure residents received their medications as prescribed for 2 of 2 residents (Resident 4 [R4], and Resident 5 [R5]). This failure resulted in R4 being hospitalized and contributed to R5's hospitalization due to missed medications.

Findings included...

Review of a facility policy titled, "Medication Non-Availability," last reviewed on

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

Residential Care Services | Date

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

Administrator (or Representative) | Date

WAC 388-78A-2210 Medication services.

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(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to implement safe medication practices to ensure residents received their medications as prescribed for 2 of 2 residents (Resident 4 [R4], and Resident 5 [R5]). This failure resulted in R4 being hospitalized and contributed to R5's hospitalization due to missed medications.

Findings included…

Review of a facility policy titled, "Medication Non-Availability," last reviewed on

02/15/2024, it stated, “The Community will make every reasonable effort to ensure that medications are available as prescribed, for each resident. A system will be in place to facilitate timely medication refills for residents whose medications are purchased from the Community's preferred pharmacy provider.” In section titled “Procedure,” it stated, “An automatic cycle refill system is encouraged to ensure timely refills of resident medication whenever feasible, and if available from the Community's preferred pharmacy provider.”

Review of the Cleveland Clinic article titled “Hypoxemia,” last reviewed on 06/15/2022, stated, “Hypoxemia is when oxygen levels in the blood are lower than normal. If blood oxygen levels are too low, your body may not work properly. Someone with low blood oxygen is considered hypoxemic… Hypoxemia can happen if you can’t breathe in enough oxygen or if the oxygen you breathe in can’t get to your blood… Depending on the severity and duration, hypoxemia can lead to mild symptoms or lead to death. Mild symptoms include headaches and shortness of breath. In severe cases, hypoxemia can interfere with heart and brain function. It can lead to a lack of oxygen in your body’s organs and tissues (hypoxia).” In the section titled, “How is hypoxemia treated?” it stated, “Medications or other treatments can help raise your blood oxygen level… Treatments, which focus on the underlying cause, may include: Inhalers with bronchodilators or steroids to help people with lung disease…”

Review of the Cleveland Clinic article titled “Blood Oxygen Level,” last reviewed on 02/18/2022, stated, “A pulse oximeter can also measure blood oxygen saturation levels through a small clip that’s usually placed on your finger or toe. An oximeter reading only indicates what percentage of your blood is saturated with oxygen, known as the SpO2 level, as well as your heart rate…For most people, a normal pulse oximeter reading for your oxygen saturation level is between 95% and 100%... A lower-than-normal blood oxygen level is called hypoxemia. Since oxygen is essential to all of your body’s functions, hypoxemia is often concerning. The lower the oxygen level, the greater likelihood for complications in body tissue and organs.”

During an interview on 02/26/2025 at 12:59PM, Staff B, the Health and Wellness Director/Licensed Nurse, was asked when floor staff would initiate a re-order for medications running out on a resident who was on their cycle fill through their in-house pharmacy. Staff B stated, “I tell them within 7 days.”

<R4>
Review of R4’s Face Sheet dated 02/26/2025, showed that R4 was admitted to the facility on [redacted]/2023.

Review of an unsigned Negotiated Service Agreement for R4, undated, showed under “Medications” that R4 required “Significant (Total) Assist by Med Tech [Medication Technician].” Under the “Medication Administration” section, under “Goals” it stated, “Resident will have medications administered per physician’s orders.” Under “Interventions” it stated, “Administer resident medications per physician’s orders as noted on the MAR [Medication Administration Record]”.

Review of the undated Resident Characteristic Roster on 02/26/2025 showed that R4 was recently hospitalized.

Review of Progress Notes for R4 showed a note written by Staff B, the Health Services Director on [redacted]/2025 at 11:45PM which stated, “This evening [R4] has been complaining of feeling sick and nauseous. [R4’s] appearance is pale and [they are] sweating profusely. [R4] seems to have trouble keeping [their] balance while ambulating (walking). Caregivers have informed this LN (Licensed Nurse) R4 has been off [their] baseline all evening. Med Tech from previous shift noted that R4 hasn't had [their Klonopin (also known as clonazepam, an anti-anxiety medication) in a few days. This LN administered one dose of ordered Klonopin @ 1930 (7:30PM). Went back to check on [R4] an hour later to find [them] sleeping in bed. Around 2230 (10:30PM) this LN found [R4] in [their] room confused, sweating, and complaining of feeling sick. At this time 911 was called to further assess [R4] and take [them] to the… ER.”

Review of R4’s MAR. dated February 2025, showed that R4 had a physician order for “Clonazepam 1mg [milligram] tab.” Instructions for the clonazepam read, “Take 1 tablet by mouth, twice daily.” Review of the documented clonazepam administrations by the facility staff showed that both doses were missed on 02/16/2025, and one dose was missed on the morning of [redacted]/2025. Review of the “Exceptions” section of the MAR showed that the reason for the missed clonazepam on 02/16/2024 for both administrations was listed as “pending refill.” For the missed administration on [redacted]/2025 the reason was listed as “ordered.”

During an interview on 02/28/2025 at 11:29AM, Collateral Contact 1 (CC1), R4’s representative, stated that on [redacted]/2025, they received a call from a facility representative notifying them that R4 was sent to an Urgent Care for withdrawal symptoms. CC1 stated that R4 was then sent to a hospital and was not discharged until the afternoon of [redacted]/2025. CC1 stated that the physician from the Urgent Care center called them around 1PM the following day, and told CC1 that if this happens again, R4 “could die.” CC1 stated this really scared them. CC1 was asked if they remembered if the physician specifically mentioned R4’s withdrawal of clonazepam when they spoke. CC1 stated, “[They] specifically said the withdrawal symptoms and low sodium.” CC1 then stated that historically when withdrawing, R4 would drink an excess amount of fluids, which would lead to the low sodium issues. CC1 then stated they were very angry because when the hospital was preparing to discharge R4 back to the facility, CC1 stated that they called the facility and spoke with Staff A, the Executive Director, to ensure they obtained the clonazepam for R4. CC1 stated that Staff A was unaware of the missing medication and stated that they did not yet obtain a new supply. CC1 stated that they then contacted the hospital to request a paper prescription, which CC1 stated they brought to a pharmacy to fill. CC1 stated they then brought the clonazepam to the facility. CC1 was asked if they recalled how many tablets were dispensed by the outside pharmacy. CC1 stated that it was a 10-day supply. CC1 then stated that after speaking with staff at the facility, that they were told that similar incidents have happened with other residents in the community.

During an interview on 02/26/2025 at 12:59PM, Staff B was asked if they could explain the circumstances behind the hospitalization of R4. Staff B stated, “[R4] was sent to the [Urgent Care] by me.” Staff B was asked to explain what happened. Staff B stated, “[R4] was having withdrawal-like symptoms from not having [their] clonazepam. I looked, and it looked like [they were] out of [their] clonazepam for 2 days. I think this happened on Monday night ([redacted]/2025). I found [R4] one dose and gave [them] the dose. [R4] seemed to be fine. I checked on [them] about 2 hours later and [they were] having some more issues.” Staff B was asked to elaborate on the issues R4 experienced. Staff B stated, “[R4] was confused, sweating, and having an upset stomach. I called [their] POA (Power of Attorney) and notified [them] and told [them] if [R4’s] symptoms continued, [they] would be sent to [the Urgent Care] and [they] agreed.” Staff B then stated, “[R4] was not improving, and eventually [they] did get sent.” Staff B was asked if R4 received their medications through the in-house pharmacy, and if they would normally receive their medications as part of the in-house pharmacy’s ‘cycle fill.’ Staff B confirmed that this was correct for R4. Staff B was asked if they investigated the issue and determined why the medication was not re-ordered timely. Staff B stated, “I did not know the medication was out. I did talk to the staff, and they stated that they needed a new order, (from the physician) and have talked to pharmacy. Pharmacy said they sent a [prescription refill request] to [R4’s] provider.” Staff B was asked if R4’s physician was contacted by facility staff to notify them of the refill request. Staff B stated, “The staff faxed the PCP [Primary Care Provider/physician].” Staff B was asked to provide faxes sent to R4’s physician by facility to request a new order for clonazepam, and to provide any faxed responses by the physician, if any, for review. Staff B stated they would provide. The fax requests to the physician were not provided to the department for review.

During an interview on 03/05/2025 at 8:59AM, CC1 stated that while visiting R4 on 02/28/2025, CC1 asked staff to show them R4’s clonazepam so they could visualize and ensure the facility did not again run out. CC1 stated that the clonazepam which was shown to them was the same bottle that they obtained themselves through a private pharmacy. CC1 stated that there were approximately 5 tablets remaining at that time. CC1 stated that during another visit to the facility on 03/03/2025, the facility had still not obtained the medication from their in-house pharmacy and reported that there were only two pills remaining of R4’s clonazepam.

<R5>
Review of R5’s Face Sheet, dated 02/26/2025, showed that R5 was admitted to the facility on [redacted]/2024.

Review of R5’s unsigned Negotiated Service Agreement, undated, showed that under “Medications” that R5 required “Significant (Total) Assist by Med Tech.” Further review of the Negotiated Service Agreement showed there was no “Medication Administration” section.

Review of the undated Resident Characteristic Roster on 02/26/2025 showed that R5 was recently hospitalized.

Review of Progress Notes for R5, dated 01/30/2025-02/16/2025, showed a note written on 02/07/2025 at 2:16PM which stated, “Resident is on alert due to missing medications.” The following note, dated [redacted]/2025 at 2:18PM stated, “Resident is on alert due to returning from the hospital.” There was no note documenting the events which required the resident to be sent to the hospital. In another note on [redacted]/2025 at 6:24PM, it stated, “[Resident] was lethargic/not at baseline… [Resident] c/o [complaints of] chest pain 911 was contacted [Resident] transported to [hospital] for eval[uation].” The preceding progress note dated [redacted]/2025 at 7:56PM stated, “Resident is back to the facility from the hospital. [They are] back with a lot of diagnosis please see after visit summary. Staff continues to monitor.”

Review of R5’s MAR, dated January 2025, showed the facility did not provide a complete record. Pages 2 through 4 were missing out of the 15-page MAR. Review of page 1 showed that R5 did not receive their Drizalma (an anti-depressant to treat mood disorders) as prescribed. The order read “Drizalma Cap 30mg [micrograms] DR. [Delayed Release] Sprinkle 1 capsule over soft food and take by mouth immediately every morning.” There was no documentation of administration of the medication from 01/01/2025 through 01/16/2025. No other medications were able to be verified as administered per the MAR provided, but review of the “Exceptions” section of the January MAR showed the following:
• “Drizalma Cap 30mg DR,” the reason the medication was not given to the resident as prescribed was listed as “pending new prescription from provider,” and “out of medication need refill”.
• “Levalbuterol (a medication used to prevent or relieve the wheezing, shortness of breath, coughing, and chest tightness) 1.25mg/0.5ml [milliliter] neb [nebulizer]” (A nebulizer is a device that turns liquid medicine into a mist). Noted the MAR showed the Levalbuteral was to be administered to R5 with morning medications. Review showed that this medication was not given to R5 as ordered from 01/01/2025 through 01/31/2025. The reason documented as to why the medication was not given was documented as “no nebulizer in cart,” “waiting for this meds to be delivered,” “waiting on pharmacy,”.
• “Trazadone (a medication for sleep) tab 100mg.” Noted this medication was to be administered at resident’s hour of sleep. Review showed that this medication was not given to R5 as ordered from 01/01/2025 through 01/31/2025. The reason documented as to why the medication was not given was documented as “waiting for this meds to be delivered,” “waiting on medication,” “pending delivery,” “out of medications need refill”.
• “Quetiapine (an anti-psychotic to treat restlessness and agitation) 50mg Tab.” Noted this medication was to be administered at resident’s hour of sleep. Review showed that this medication was not given to R5 as ordered from 01/04/2025 through 01/31/2025. The reason documented as to why the medication was not given was documented as “waiting on medication,” “pending delivery,” “out of medications need refill,”.
Review of R5’s MAR, dated February 2025, showed the following:
• “Levalbuterol 1.25mg/3ml neb.” Noted the prescription was an increase in frequency from the January 2025 MAR. Instructions read, “Inhale contents of 1 vial via nebulizer three times daily.” Review showed that this medication was circled, which designated that it was not given to R5 as ordered from 02/08/2025 through 02/10/2025. From 02/11/2025 through 02/15/2025 there was no documentation of administration of the

medication at all and again was circled as not given from 02/16/2025 through 02/24/2025. Review of the Exception section showed there was no documentation of administration until 02/08/2025 forward, which documented the reason as to why the medication was not given as “awaits delivery,” “unavailable,” “waiting on pharmacy,”.
• “Quetiapine 50mg Tab.” Order read, “Take 1 tablet by mouth every day for restless agitation,” with an administration time of 8:00PM. Review showed that this medication was circled as not given from 02/01/2025 through 02/08/2025, when R5 returned to the facility with the order discontinued. Review of the Exception section showed the reason documented as to why the medication was not given was documented as “awaits delivery,” “need new rx [prescription],”.
• “Trazadone tab 100mg.” Order read, “Take 1 tablet by mouth every evening for sleeplessness” with an administration time of 8:00PM. Review showed that this medication was circled as not given from 02/01/2025 through 02/09/2025. No other documentation of administration was noted. Review of the Exception section showed the reason documented as to why the medication was not given was documented as “awaits delivery,” “need new rx (prescription),” “no rx not delivered yet”.

Review of R5’s “Physician Discharge Summary”, dated 02/15/2025, from R5’s hospitalization from [redacted]/2025 to [redacted]/2025 listed “[redacted],” and “[redacted] as part of their admission diagnosis. In the section titled “Brief Hospital Course” it stated, “EMS (Emergency Medical Services) was called and noticed hypoxia with SpO2 = 84%.”

In an interview on 03/05/2025 at 03:03PM, Staff B was asked why medications for R5 were not given per physician order. Staff B stated they never recalled R5 to have a nebulizer machine in the facility. Staff B then stated that they thought they remembered trying to get R5’s Levalbuterol discontinued. Staff B was then asked if they felt that the missed medications, including the Levalbuterol nebulizer, may have resulted in R5 having to seek out medical treatment at the hospital for chest pain and weakness. Staff B stated, “I can’t rule that out.”

This is a 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)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-3140 Responsibilities during inspections. The assisted living facility must:

(2) Provide requested records to the representatives of the department; and

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to provide requested documentation for 5 of 5 residents reviewed, (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], Resident 4 [R4], and Resident 5 [R5]). This failure resulted in the department not being able to conduct thorough investigations for reported allegations , which placed all 51 of 51 residents in the facility at risk for ongoing abuse, not receiving agreed upon services, and an overall decreased quality of life.

Findings included…

Review of a Dear Provider Letter dated 03/21/2024 stated, “This letter is to inform you of document access requirements during Residential Care Services (RCS) inspection, investigation, and certification visits… Record review is a core function essential to regulatory work. Timely access to records is expected and requested during regulatory visits… Documents can be provided in the following ways…
1. Provide RCS staff access to paper and electronic records during their visit. Access to electronic records can be temporary and restricted to requested documents.
2. RCS Email: You may scan and email documents to the relevant secure email address for your region or directly to staff as requested…
Note: If requested documents are unable to be provided during the visit it is expected that requested documents be electronically sent within 24 hours unless otherwise specified by RCS staff.”

Review of department records showed a facility report of a resident-to-resident altercation involving R1 and R2, which occurred in the facility on 01/29/2025. Further review showed an additional facility report of a resident-to-resident altercation involving

R1 and R3 which occurred in the facility on 02/18/2025.

In an interview on 02/26/2025 at 9:52AM, Staff A, the Executive Director, was asked to clarify if Temporary Service Plans were created to implement interventions to prevent future incidents and notify staff, when there was a resident-to-resident altercation that occurred in the community. Staff A confirmed that a Temporary Service Plan would be created. The following documentation was then requested from Staff A for review by the department:
<R1>
• Face Sheet
• Incident Report for incident on 01/29/2025
• Incident Report for incident on 02/18/2025
• Most recent, signed Negotiated Service Agreement
• Temporary Service Plan created for the Incident on 01/29/2025
• Temporary Service Plan created for the Incident on 02/18/2025
• Progress Notes/Alert Charting regarding the incident on 01/29/2025, per facility protocol.
• Progress Notes/Alert Charting regarding the incident on 02/18/2025, per facility protocol.
<R2>
• Face Sheet
• Incident Report for incident on 01/29/2025
• Most recent, signed Negotiated Service Agreement
• Temporary Service Plan created for the Incident on 01/29/2025
• Progress Notes/Alert Charting regarding the incident on 01/29/2025, per facility protocol.
<R3>
• Face Sheet
• Incident Report for incident on 02/18/2025
• Most recent, signed Negotiated Service Agreement
• Temporary Service Plan created for the Incident on 02/18/2025
• Progress Notes/Alert Charting regarding the incident on 02/18/2025, per facility protocol.
Staff A was observed to write down the requested documentation.

At 11:31AM on 02/26/2025, the facility provided three folders containing resident information for review. Review of the three folders showed that of the requested information, only Face Sheets, and Progress Notes were provided for R1, R2 and R3.

At 12:05PM on 02/26/2025, Staff A and Staff B, the Heath Services Director, were both asked to provide an update on the requested documentation that had not yet been provided. Staff B stated they were not aware what other documentation was needed. Staff A was asked if they could share the written list of requested documentation with Staff B so they may assist in obtaining the requested documentation. The following additional information was then requested from Staff B to investigate a separate concern of care and services not being provided:
<R4>
• Face Sheet

• Most recent, signed Negotiated Service Agreement
• Active Physician Orders
• Medication Administration Record for January and February 2025
• Last 30 days of Progress Notes
• After Visit Summary, or Hospital Discharge Notes from most recent hospital visit

<R5>
• Face Sheet
• Most recent, signed Negotiated Service Agreement
• Active Physician Orders
• Medication Administration Record for January and February 2025
• Last 30 days of Progress Notes
• After Visit Summary, or Hospital Discharge Notes from most recent hospital visit
Staff A then provided Incident Reports for R1, and R3, for the incident which occurred on 02/18/2025.

During an interview with Staff B, on 02/26/2025 at 12:59PM, some additional concerns arose regarding R4 not receiving their medication as prescribed, which resulted in them being sent to the hospital for evaluation. The following information was then also requested to be provided:
• A copy of fax notification, from the facility to the provider, to request a new prescription order of Clonazepam (anti-anxiety) for R4
• Alert Charting List for the last 30 days
Staff B was then notified that due to the time in which it was taking the facility staff to provide documentation, the department representative would be leaving the facility for the day. Staff B was asked if it were possible for them to send all the remaining documentation via email, by 10:00AM the following day, on 02/27/2025. Staff B stated, “That won’t be a problem.”

At 1:13PM on 02/26/2025, Staff A was then notified that due to the time in which it was taking the facility staff to provide documentation, the department representative would be leaving the facility for the day. Staff A was asked if it were possible for them to send all the remaining documentation via email, by 10:00AM the following day, on 02/27/2025. Staff A agreed that the documents would be sent.

As of 02/27/2025 at 11:05AM, the facility had not sent any additional documentation to review.

On 02/27/2025 at 1:05PM, the department representative met with Staff A, and Staff B at the facility. Staff A was asked why there was no additional documentation sent to review. Staff A was observed to hold up 2 folders with additional requested resident information. Staff A was asked if these 2 folders included all the documentation which was requested. Staff A stated they were not sure and provided the folders. Staff A was asked again why these documents were not sent via email, as previously agreed. Staff A stated that Staff B was called to work on the floor with residents the previous evening and was unable to send the documents. Staff A was asked if Staff B was the only person

in the facility that could send these documents. Staff A was then observed to shrug their shoulders, and did not give a response.

At 2:30PM, on 02/27/2025, the 2 folders were reviewed. After review, it was noted that the following information was still not provided:
• Alert Charting list for the last 30 days.
<R1>
• Most recent, signed Negotiated Service Agreement
• Incident Report for incident on 01/29/2025
• Temporary Service Plans created for the Incident on 01/29/2025
• Temporary Service Plans created for the Incident on 02/18/2025
<R2>
• Most recent, signed Negotiated Service Agreement
• Incident Report for incident on 01/29/2025
• Temporary Service Plans created for the Incident on 01/29/2025
<R3>
• Most recent, signed Negotiated Service Agreement
• Temporary Service Plans created for the Incident on 02/18/2025
<R4>
• Medication Administration Record (January 2025) missing pages 2-14.
• A copy of fax notification, from the facility to the provider, to request a new prescription order of Clonazepam.
• Active Physician Orders
<R5>
• Active Physician Orders

As of 03/07/2025 the requested records were not received.

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