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

06/25/2025

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) 61622 (Completion Date 06/25/2025) and 59785 (Completion Date 05/22/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/25/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

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

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 05/19/2025 and 05/22/2025 of:

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

This document references the following SOD dated: 05/22/2025

The following sample was selected for review during the unannounced on-site visit: 0 of 41 current residents and 0 former residents.

The department staff that inspected 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

Statement of Deficiencies	License #: 2600	Compliance Determination # 59785
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 2 of 4	Licensee: Greenlake Management Lacey, LLC	05/22/2025

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.

Clinton Fridley
Residential Care Services

05/30/2025
Date

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

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

05/31/2025
Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to secure potentially hazardous supplies accessible to memory care residents for 2 of 2 buildings reviewed (Lodge 1 and Lodge 2). This failure placed all 41 of 41 residents at risk for access to and potential ingestion/exposure of harmful chemicals.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 03/28/2025, 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-3100] 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 C, Former Administrator, signed the document on 04/11/2025. Staff C 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 04/27/2025."

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

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to secure potentially hazardous supplies accessible to memory care residents for 2 of 2 buildings reviewed (Lodge 1 and Lodge 2). This failure placed all 41 of 41 residents at risk for access to and potential ingestion/exposure of harmful chemicals.

Findings included…

Record review of the “Department of Social And Health Services” document, Completion date 03/28/2025, 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-3100] 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 C, Former Administrator, signed the document on 04/11/2025. Staff C 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 04/27/2025.”

Record review of the facility Resident Characteristics Roster, dated 05/19/2025, showed the facility had 41 of 41 residents identified as having Dementia (a disease that impairs memory, thinking, and the ability to perform daily activities) or cognitive impairment.

During an interview on 05/19/2025 at 09:48AM, Staff B, Clinical Support Specialist, was asked what actions were taken to ensure harmful chemicals were properly stored and kept out of reach of residents after their previous citation. Staff B stated, “There was an In-service [staff education] done… Locks were purchased and placed… Management is also doing daily walkthroughs making sure things are locked up, and there is nothing in there.”

In an observation on 05/19/2025 at 10:11AM, in Lodge 2, a secured memory care building, observed in a resident common area with cabinets and a sink, child locks were placed on the cabinet bars. Some locks were observed to be in place, and engaged, but other locks were observed to be left unlocked, and left hanging on the cabinet bars. The cabinet below the sink was left unlocked. In the unlocked cabinet were three bottles of blue window cleaner which read, “Keep out of reach of children,” and one can of disinfectant which read, “Keep out of reach of children.”

In an observation on 05/19/2025 at 10:14AM, in Lodge 1, a secured memory care building, observed in a resident common area with cabinets and a sink, child locks placed on the cabinet bars. Some locks were observed to be in place, and engaged, but other locks were observed to be left unlocked, and left hanging on the cabinet bars. The upper right cabinet was left unlocked. In the unlocked cabinet was one bottle of hand sanitizer, and 2 bottles of lotion. The cabinet below the sink was also left unlocked. In the unlocked cabinet was one bottle of hand sanitizer, one bottle of antibacterial liquid hand soap, and one can of disinfectant which read, “Keep out of reach of children.”
In an interview on 05/19/2025 at 12:15 PM, Staff A, Director of Operations-West/Interim Executive Director, stated that the chemicals should have been stored in the cabinets with the locks engaged and in place.

This is an uncorrected deficiency previously cited on 03/28/2025.

Statement of Deficiencies	License #: 2600	Compliance Determination # 59785
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 4 of 4	Licensee: Greenlake Management Lacey, LLC	05/22/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 06/18/2025 .

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

Director of Operations

Patricia Santos-Love
Administrator (or Representative)

05/31/2025
Date

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2600
Intake ID: 170841
Compliance Determination #: 56738
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 03/21/2025 through 03/28/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Public report of a resident-to-resident altercation in the community.
2. Physical Environment: Public allegation of uncleanly environment, and broken resident furnishings.
3. Administration/Personnel: Public report of concerns with staffing in the facility.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 15 Closed records sample size: 1
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Residents Nursing staff Family members Housekeeping staff Management
Record Reviews:	Facility policies Negotiated Service Agreements Incident Reports Incident investigation Progress Notes Hospital Records

Investigation Summary:

1. Quality of Care/Treatment: Facility investigated incident, and protected residents

per policy. Facility made appropriate notifications, and monitored residents per policy. No failed practice.
2. Physical Environment: Facility observed to have unclean conditions in resident living areas. Observations also made of broken closet door in resident room. Claims substantiated. Failed practice identified.
3. Administration/Personnel: Staffing concerns were addressed under Statement of Deficiencies dated 02/13/2025. Facility is in their plan of correction phase to address non compliance.

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: 170741
Compliance Determination #: 56738
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 03/21/2025 through 03/28/2025
Complainant Contact Date(s):

Allegation(s):

1. Resident/Patient/Client Neglect: Public allegation of facility failing to treat medical concerns of residents.
2. Physical Environment: Public allegation of uncleanly environment.
3. Nursing Services: Public allegation of facility failing to treat medical concerns of residents.
4. Misappropriation of Property: Public allegation of facility losing resident property.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 15 Closed records sample size: 1
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Residents Nursing staff Family members Housekeeping staff Management
Record Reviews:	Facility policies Negotiated Service Agreements Incident Reports Incident investigation Progress Notes Hospital Records

Investigation Summary:

1. Resident/Patient/Client Neglect: Allegations of medical concerns were not able to be substantiated. No failed practice.
2. Physical Environment: Facility observed to have unclean conditions in resident living areas. Claims substantiated. Failed practice identified.
3. Nursing Services: Allegations of medical concerns were not able to be substantiated. No failed practice.
4. Misappropriation of Property: All missing resident property was located, and returned to resident/family. No failed practice.

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: 171050
Compliance Determination #: 56738
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 03/21/2025 through 03/28/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Public report of resident being abused by other residents in the community.
2. Physical Environment: Public allegation of uncleanly environment.
3. Resident/Patient/Client Rights: Public allegation of facility failing to uphold resident rights.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 15 Closed records sample size: 1
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Residents Nursing staff Family members Housekeeping staff Management
Record Reviews:	Facility policies Negotiated Service Agreements Incident Reports Incident investigation Progress Notes Hospital Records

Investigation Summary:

1. Quality of Care/Treatment: Facility investigated incident, and protected residents

per policy. Facility made appropriate notifications, and monitored residents per policy. No failed practice.
2. Physical Environment: Facility observed to have unclean conditions in resident living areas. Claims substantiated. Failed practice identified.
3. Resident/Patient/Client Rights: Facility following care as per negotiated service agreement. Facility has interventions in place for resident behaviors, and accommodating resident. No failed practice.

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: 170091
Compliance Determination #: 56738
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 03/21/2025 through 03/28/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Public report of resident care and services not being provided as per service agreement.
2. Physical Environment: Public allegation of uncleanly, and poorly maintained environment.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 15 Closed records sample size: 1
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Residents Nursing staff Family members Housekeeping staff Management
Record Reviews:	Facility policies Negotiated Service Agreements Incident Reports Incident investigation Progress Notes Hospital Records

Investigation Summary:

1. Quality of Care/Treatment: After record review and interview, there is insufficient evidence to substantiate claims of care and services not being provided as per the

service agreement.
2. Physical Environment: Facility observed to have unclean conditions in resident living areas. Claims substantiated. 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: 172671
Compliance Determination #: 56738
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 03/21/2025 through 03/28/2025
Complainant Contact Date(s):

Allegation(s):

1. Physical Environment: Public report of residents feeling ill after emergency plumbing issue from septic backup.
2. Infection Control: Public report of residents feeling ill after emergency plumbing issue from septic backup.
3. Quality of Care/Treatment: Public report of residents feeling ill after emergency plumbing issue from septic backup.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 15 Closed records sample size: 1
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Residents Nursing staff Family members Housekeeping staff Management
Record Reviews:	Facility policies Negotiated Service Agreements Incident Reports Incident investigation Progress Notes Hospital Records

Investigation Summary:

1. Physical Environment: Facility observed to have unclean conditions in resident living areas, placing residents at risk of health concerns. Claims substantiated. Failed practice identified.
2. Infection Control: Facility observed to have unclean conditions in resident living areas, placing residents at risk of health concerns. Claims substantiated. Failed practice identified.
3. Quality of Care/Treatment: Facility observed to have unclean conditions in resident living areas, placing residents at risk of health concerns. Claims substantiated. 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 03/21/2025, 03/25/2025 and 04/01/2025 of:

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

This document references the following complaint number(s): 170841, 170741, 171050, 170091, 170143, 172671

The following sample was selected for review during the unannounced on-site visit: 15 of 46 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI
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 # 557736
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 2 of 10	Licensee: Greenlake Management Lacey, LLC	03/28/2025

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

04/07/2025
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)

4/11/2025
Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to secure potentially hazardous supplies accessible to memory care residents for 2 of 2 buildings reviewed (Lodge 1 and Lodge 2). This failure placed all 46 of 46 residents at risk for access to and potential ingestion of harmful chemicals.

Findings included:

Record review of the facility Resident Characteristics Roster, dated 03/21/2025, showed the facility had 46 of 46 residents identified as having Dementia (a disease that impairs memory, thinking, and the ability to perform daily activities) or cognitive impairment. Resident 8 (R8), Resident 9 (R9), Resident 10 (R10), Resident 11 (R11), Resident 5 (R5), and Resident 12 (R12) were identified as having dementia/cognitive impairment.

In an observation on 03/25/2025 at 3:41 PM, in Lodge 2, a secured memory care building, in the cabinet by the sink in the resident dining and activity area were two large containers of Chemical Sani-Cloth Germicidal disposable wipes. The label of the

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…

Record review of the facility Resident Characteristics Roster, dated 03/21/2025, showed the facility had 46 of 46 residents identified as having Dementia (a disease that impairs memory, thinking, and the ability to perform daily activities) or cognitive impairment. Resident 8 (R8), Resident 9 (R9), Resident 10 (R10), Resident 11 (R11), Resident 5 (R5), and Resident 12 (R12) were identified as having dementia/cognitive impairment.

In an observation on 03/25/2025 at 3:41 PM, in Lodge 2, a secured memory care building, in the cabinet by the sink in the resident dining and activity area were two large containers of Chemical Sani-Cloth Germicidal disposable wipes. The label of the

wipes read "Keep out of reach of children." Under the unlocked cabinet below the sink were four bottles of blue window cleaner. In the upper unlocked cabinet was nail enamel dryer, with a label warning of "keep out of reach of children." In the cabinet was a bottle of Sterile Saline would wash, hand sanitizer, and liquid hand soap. At the table next to the sink and cabinets with unsecured chemicals sat three residents, R8, R9, and R10.

In an observation on 03/25/2025 at 4:11 PM, in Lodge 1, a secured memory care building, in the cabinet by the sink in the resident dining and activity area was a can of disinfectant deodorant, with a label warning of "Keep out of reach of children." In the unlocked cabinet there was a container of Sani- Cloth Germicidal Wipes with a label warning of "Keep out of reach of children," a bottle of antibacterial soap, and hand sanitizer. Under the sink in the unlocked cabinet was a can of disinfectant deodorant that's label warning showed "keep out of reach of children," hand sanitizer, liquid shampoo and body wash, and a bottle of lotion. At the table next to the sink and cabinets with unsecured chemicals sat three residents, R11, R5, and R12.

In an interview on 03/25/2025 at 4:00 PM, Staff D, Caregiver, stated chemicals should be locked up and not accessible to the residents.

In an interview on 03/25/2025 at 4:48 PM, Staff E, Executive Director, stated that the expectation was for chemicals to be locked and secured in the memory care units.

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) 4/27/2025.

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

Administrator (or Representative) 4/11/2025 Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

wipes read “Keep out of reach of children.” Under the unlocked cabinet below the sink were four bottles of blue window cleaner. In the upper unlocked cabinet was nail enamel dryer, with a label warning of “keep out of reach of children.” In the cabinet was a bottle of Sterile Saline would wash, hand sanitizer, and liquid hand soap. At the table next to the sink and cabinets with unsecured chemicals sat three residents, R8, R9, and R10.

In an observation on 03/25/2025 at 4:11 PM, in Lodge 1, a secured memory care building, in the cabinet by the sink in the resident dining and activity area was a can of disinfectant deodorant, with a label warning of “Keep out of reach of children.” In the unlocked cabinet there was a container of Sani- Cloth Germicidal Wipes with a label warning of “Keep out of reach of children,” a bottle of antibacterial soap, and hand sanitizer. Under the sink in the unlocked cabinet was a can of disinfectant deodorant that’s label warning showed “keep out of reach of children,” hand sanitizer, liquid shampoo and body wash, and a bottle of lotion. At the table next to the sink and cabinets with unsecured chemicals sat three residents, R11, R5, and R12.

In an interview on 03/25/2025 at 4:00 PM, Staff D, Caregiver, stated chemicals should be locked up and not accessible to the residents.

In an interview on 03/25/2025 at 4:48 PM, Staff E, Executive Director, stated that the expectation was for chemicals to be locked and secured in the memory care units.

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-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on observations, record review, and interview, the memory care facility failed to maintain a safe, and sanitary living environment for 7 of 9 (Resident 1 [R1], Resident 3 [R3], Resident 6 [R6], Resident 7 [R7], Resident 13 [R13], Resident 14 [R14], and Resident 15 [R15]) residents reviewed. These failures placed residents as risk for a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions for all residents.

Findings included…

“RCW 70.129.005 Intent—Basic rights. ‘…The legislature intends that a facility should care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. A resident should have a safe, clean, comfortable, and homelike environment…”

“RCW 70.129.140 Quality of life—Rights. (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.”

Review of a facility policy titled “General: Services and Operation,” dated 02/15/2024, stated, “Consistent with the resident’s assessed needs and negotiated service agreement this community [will] provide housing, and assume general responsibility for the safety and well-being of each resident… This community will provide basic services… Housekeeping.”

During an interview on 03/24/2025 at 11:35AM, Staff A, The Director of Operations, was asked who was responsible for cleaning resident rooms. Staff A replied that Housekeeping was responsible. Staff A was asked how often resident rooms were to be cleaned. Staff A replied that resident rooms should be cleaned “once a week, and/or as needed in-between.” Staff A was asked what type of cleaning was done in resident rooms. Staff A replied, “Linen change, personal laundry pick-up and launder, sweep, mop, vacuum, dust, cleaning bathroom, toilet, sink, counter, remove any trip hazards, trash removal.” Staff A was asked if resident rooms were found to be soiled, to explain the expectations of staff, and process to get the room cleaned. Staff A replied, “Care staff [are] to clean or remove soiled items if housekeepers are not on shift or available. Maintenance Director [is] to assist housekeeping team as needed in the event they are unable. All soiled items should be removed if observed by any staff member or request item(s) to be removed by a member of housekeeping if care staff are unable to address tasks immediately.”

Review of Department records showed a report made to the Department on 03/05/2025 which stated that stated resident living conditions were “filthy” and alleged that there was uncleaned “feces that had been there for weeks.”

Review of Department records showed two separate reports made to the Department on 03/11/2025. One report alleged there was uncleaned feces on the bathroom floor, and soiled briefs being left on the bathroom floors, and the second report alleged that R3 had a broken closet door that was not being fixed.

Review of Department records showed a report made to the Department on 03/23/2025 which reported an emergency plumbing and water issue involving the septic system, which led to flooding out of all resident toilets in Lodge 2. It stated, "all bathrooms and laundry rooms are flooded… the carpet was wet and smelled…"

<R3>
Review of R3's Face Sheet, dated 03/2025, showed that R3 was admitted to the facility on [redacted]/2024.

During an interview on 03/21/2025 at 10:20AM, R3 was asked if they had a broken closet door. R3 pointed over towards their closet and said, "Oh yeah, big time." Observed there to be a white, wooden 2-panel folding closet door that was off the track and propped up against the wall next to the closet. R3 was asked if this had been broken for a long time. R3 stated, "It was never really fixed ever." R3 was asked if it bothered them that it was propped up against the wall. R3 stated, "I know where it is, so I try and stay away from it, because I know if it fell on me, I know it would hurt like hell."

During an interview with Staff B, the Health Services Director, on 03/21/2025 at 11:10AM, Staff B was asked if they were aware of the broken closet door in R3's room. Staff B stated they were not aware. Staff B was notified that the closet door was propped up against the wall, and presented as a hazard, and placed R3 at risk for injury. Staff B agreed, and stated they would remove the door immediately until it could be fixed.

<R1, R6, and R7>
During an interview with Collateral Contact 2 [CC2], a facility housekeeper, on 03/21/2025 at 6:00PM, CC2 was asked if there was one housekeeper per lodge (Lodge 1 and Lodge 2), or if they were responsible for cleaning both lodges. CC2 stated that there was one housekeeper per lodge. CC2 was asked to explain the process for cleaning resident rooms. CC2 stated that they were supposed to clean four resident rooms per day, and to rotate through all the rooms per week. CC2 stated that because the rooms were so dirty, they would have to clean all of them daily. CC2 stated that if they were on-shift, that caregivers "are supposed to let me know, so I can go clean it, but they don't. When I am not here, nobody cleans it until I get back." CC2 stated that caregivers were supposed to assist and to clean feces or other messes while they were off shift but stated that caregivers did not do any cleaning at all. CC2 stated that this often resulted in resident rooms to go uncleaned until they saw the dirty rooms/bathrooms themselves. CC2 stated, "That makes me upset, because I don't want them (residents) living like that."

During an interview with Collateral Contact 1 [CC1], R1's representative, on 03/20/2025 at 2:51PM, CC1 was asked if they had any concerns for R1's environment. CC1 stated that they had severe concerns with cleanliness in R1's room. CC1 stated that there was uncleaned feces in R1's bathroom, which was not cleaned for weeks. CC1 was asked where this feces was located, and if it was ever cleaned. CC1 stated that R1 has moved out of the community but stated, "Under the sink there is an elbow in the pipe. They had some sort of cloth around it, and it had feces on it. It was still there when [R1] left."

Review of R1's Face Sheet, dated 03/21/2025, showed that R1 was admitted to the facility on [redacted]/2024, and lived in room [redacted]. Under "Resident Status" it stated, "Moved Out."

Review of a "Move-Out Report" from [redacted]/2025 to [redacted]/2025 showed that R1 moved out of the facility on [redacted]/2025.

During an onsite visit to the memory care facility on [redacted]/2025 at 9:58AM, room [redacted] was observed to have two residents occupied the room, R6, and R7.

Review of R6's Face Sheet, dated 03/22/2025, showed that R6 was admitted to the facility on [redacted]/2014.

Review of R7's Face Sheet, dated 03/22/2025, showed that R7 was admitted to the facility on [redacted]/2025, and was moved into room [redacted].

In an observation on 03/21/2024 at 9:58AM, upon entering resident room [redacted], the room was noted to be a double occupancy room, with a shared resident bathroom. In the resident bathroom, adjacent to the toilet, was the sink. Under the sink was a thick beige, L-shaped cloth covering the exposed piping. On the side of the cloth which faced the toilet, there was a dried, brown substance on the cloth, about 4x4 inches in size, that had the appearance of feces. A soiled brief was also observed to be left on the floor behind the bathroom door.

During observations of random resident rooms at 10:45AM on 03/21/2025, resident room [redacted] was observed to have a small amount of smeared feces on the rear of the toilet seat, and a small-moderate amount of dried yellow urine near the back and hinges of the toilet seat. There was also a dried coffee spill observed in front of the toilet on the floor.

During an interview on 03/20/2025 at 11:47AM, Staff C, the Maintenance Director, was asked to observe the soiled cloth in the bathroom of room [redacted] which was covering the piping under the sink. Staff C was then asked to examine and identify the brown substance which was on the side of the fabric. Staff C was asked if this brown substance

could be identified as rust, or grease. Staff C examined the cloth and stated, “Oh no, that’s poop.” Staff C stated they were not sure the reasoning for this fabric to be placed and left on the piping, and stated they thought that a resident must have wiped their soiled hands on the fabric after having a bowel movement.

On 03/24/2025 at 11:35AM, Staff A was asked to provide a housekeeping policy, outlining the process in which resident rooms were to be cleaned. Staff A stated that there was no specific housekeeping policy.

<R13, R14, and R15>
During an interview on 03/25/2025 at 4:03PM, Staff F, the Resident Care Coordinator, was asked to explain what happened with the recent flooding in the facility. Staff F stated, “They called me to report a flood in one of the resident rooms and many rooms.” Staff F was asked if Lodge 1 was affected, or if it just affected Lodge 2. Staff F confirmed it affected only Lodge 2. Staff F stated, “I am the one that contacted [Staff C and Staff E, the Executive Director]. They both beat me here. When we got here, we started making rounds and trying to figure out where it was coming from. We started clean-up duties. [Staff C] and [Staff E] took over that.” Staff F stated that primarily the resident rooms were affected, as the bathrooms were flooding from the toilets. Staff F stated that the rooms were at the time, sopping wet. Staff F was asked if any residents had to be moved to another area. Staff F stated no residents were moved out of their rooms.

During an onsite visit to the facility on 03/25/2025 at 3:42PM, after entering Lodge 2, there was a noticeable smell of urine/stool, mixed with some sort of deodorizer/fragrance. There was evidence the facility was working to dry the carpets, however the carpets were observed to still be wet. Noted the moisture could be felt while walking on the carpet with shoes on. Further observations showed that the areas that were affected included all resident rooms, the common areas such as the TV and dining areas, and laundry room. Observed there to be multiple residents sitting out in the TV, and dining areas. Observed R13 to be sitting on a bench, in the TV area, with no socks, or any other footwear. Further observations showed R14 to be sitting in a wheelchair in the dining room area, with a blanket on their lap. The blanket was observed to have about half of its volume lying on the soiled/wet floor.

During an interview with R15, on 03/25/2025 at 4:11PM, R15 was asked if they could elaborate on the recent incident at the facility involving the flooding of the toilets. R15 stated, “They turned off the water so they could fix the issue. It was off ALL day.” R15 was asked if the flooding/septic back-up affected them in any way. R15 stated, “It just made me feel sick... I threw up in the toilet because the smell was so bad.”

This is a recurring deficiency previously cited on 04/27/2023 and 01/10/2023 for subsections (1)(a)(c).

Statement of Deficiencies	License #: 2600	Compliance Determination #:56736
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 8 of 10	Licensee: Greenlake Management Lacey, LLC	03/28/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 4/27/2025

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

Administrator (or Representative) 4/11/2025 Date

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

(2) Any unusual incident that required implementation of the assisted living facility's disaster plan, including any evacuation of all or part of the residents to another area of the assisted living facility or to another address, and

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

This requirement was not met as evidenced by:

Based on observations, record review, and interview, the memory care facility failed to make a report to the Department after an incident occurred in the facility which threatened their ability to ensure continuation of services to residents, for 1 of 1 incident reviewed. This failure resulted in the Department being unable to investigate the incident immediately and placed all 46 of 46 residents at risk for health-related concerns and at risk of not receiving agreed upon services.

Findings included ..

Review of Department records showed a public report made to the Department on 03/23/2025 which reported an emergency plumbing and water issue involving the septic system, which led to flooding out of all resident toilets in Lodge 2 .. It stated, "all bathrooms and laundry rooms are flooded .. the carpet was wet and smelled .."

During an onsite visit to the facility on 03/25/2025 at 3.42PM, after entering Lodge 2, there was a noticeable smell of urine/stool, mixed with some sort of deodorizer/fragrance. There was evidence the facility was working to dry the carpets, however the carpets were observed to still be wet. Noted the moisture could be felt while walking on the carpet with shoes on. Further observations showed that the areas that were affected included all resident rooms, the common areas such as the TV and

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

_____ _____
Administrator (or Representative) Date

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Review of Department records showed a public report made to the Department on 03/23/2025 which reported an emergency plumbing and water issue involving the septic system, which led to flooding out of all resident toilets in Lodge 2… It stated, "all bathrooms and laundry rooms are flooded… the carpet was wet and smelled…"

During an onsite visit to the facility on 03/25/2025 at 3:42PM, after entering Lodge 2, there was a noticeable smell of urine/stool, mixed with some sort of deodorizer/fragrance. There was evidence the facility was working to dry the carpets, however the carpets were observed to still be wet. Noted the moisture could be felt while walking on the carpet with shoes on. Further observations showed that the areas that were affected included all resident rooms, the common areas such as the TV and

dining areas, and laundry room. Observed there to be multiple residents sitting out in the TV, and dining areas.

During an interview on 03/25/2025 at 3:47PM, Resident 8 (R8) was asked to discuss any concerns with flooding in the facility. R8 stated, “Two nights ago all of the toilets were blocked. And I don’t know how many of them, but several of them are overflowing.”

During an interview on 03/25/2025 at 4:03PM, Staff F, the Resident Care Coordinator, was asked to explain what happened with the recent flooding in the facility. Staff F stated, “They called me to report a flood in one of the resident rooms and many rooms.” Staff F was asked if Lodge 1, or if it just affected Lodge 2. Staff F confirmed it affected only Lodge 2. Staff F stated, “I am the one that contacted [Staff C, Maintenance Director, and Staff E, Executive Director]. They both beat me here. When we got here, we started making rounds and trying to figure out where it was coming from. We started clean-up duties. [Staff C] and [Staff E] took over that.” Staff F stated that primarily the resident rooms were affected, as the bathrooms were flooding from the toilets. Staff F stated that the rooms were at the time, sopping wet. Staff F was asked if any residents had to be moved to another area. Staff F stated no residents were moved out of their rooms. Staff F was asked if the water was ever turned off. Staff F confirmed that it was but was uncertain of the duration. Staff F was asked if any emergency or disaster protocols were initiated. Staff F stated that they did not think so. Staff F was asked if incidents such as this should be reported to the Department. Staff F stated, “I would think so, yes.”

During an interview on 03/25/2025 at 4:11PM, Resident 15 (R15) was asked if they could elaborate on the recent incident at the facility involving the flooding of the toilets. R15 confirmed there was flooding in their room, and stated, “They turned off the water so they could fix the issue.” R15 was asked how long the water was off. R15 stated, “It was turned off all day.” R15 was asked if they could give a more specific time frame to which the water was turned off. R15 then was observed to widen their eyes and re-stated, “It was off ALL day!”

During an interview with Staff E, the Executive Director, on 03/25/2025 at 4:31PM, Staff E was asked what was done once they arrived onsite after learning of the septic backup/flooding to Lodge 2. Staff E stated, “[Staff C] and I were both here, extracting water, and making sure [residents] had water for what they need.” Staff E stated that the water in Lodge 2 was turned off and stated that they had to use the emergency supply water to care for the residents. Staff E was asked if the facility notified the Department of the flooding/water shut off. Staff E stated, “No, I did not because we still had access to a toilet, and emergency water.” Staff E was asked if they thought accessing the emergency water, would imply that emergency/disaster preparedness plan was initiated. Staff E then stated that they agreed and stated that they probably should have reported the incident to the Department.

Review of Department records on 03/25/2025 at 3:00 PM showed no report made by the facility to report any flooding, septic issues, or implementation of any disaster plans.

Statement of Deficiencies	License #: 2600	Compliance Determination #:55738
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 10 of 10	Licensee: Greenlake Management Lacey, LLC	03/28/2025

This is a recurring deficiency previously cited on 05/08/2024 for subsection (3).

Plan/Attestation Statement

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

Administrator (or Representative) — Date: 4/11/2025

This is a recurring deficiency previously cited on 05/08/2024 for subsection (3).

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date