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

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

RE: Memory Care At The Lodges License # 2600

Dear Administrator:

This letter addresses Compliance Determination(s) 67169 (Completion Date 10/14/2025) and 62995 (Completion Date 07/23/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/14/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2130-1, WAC 388-78A-2130-1-a, WAC 388-78A-2130-1-b, WAC 388-78A-2130-1-c, WAC 388-78A-2130-2, WAC 388-78A-2090, WAC 388-78A-2090-1, WAC 388-78A-2090-1-a, WAC 388-78A-2090-1-b, WAC 388-78A-2090-1-c, WAC 388-78A-2090-2, WAC 388-78A-2090-2-a, WAC 388-78A-2090-2-b, WAC 388-78A-2090-2-c, WAC 388-78A-2090-3, WAC 388-78A-2090-4, WAC 388-78A-2090-4-a, WAC 388-78A-2090-4-b, WAC 388-78A-2090-5, WAC 388-78A-2090-5-a, WAC 388-78A-2090-5-b, WAC 388-78A-2090-5-c, WAC 388-78A-2090-6, WAC 388-78A-2090-6-a, WAC 388-78A-2090-6-b, WAC 388-78A-2090-6-c, WAC 388-78A-2090-6-d, WAC 388-78A-2090-6-e, WAC 388-78A-2090-7, WAC 388-78A-2090-7-a, WAC 388-78A-2090-7-b, WAC 388-78A-2090-7-c, WAC 388-78A-2090-7-c-i, WAC 388-78A-2090-7-c-ii, WAC 388-78A-2090-7-d, WAC 388-78A-2090-8, WAC 388-78A-2090-8-a, WAC 388-78A-2090-8-b, WAC 388-78A-2090-8-b-i, WAC 388-78A-2090-8-b-ii, WAC 388-78A-2090-9, WAC 388-78A-2090-10, WAC 388-78A-2090-11, WAC 388-78A-2090-11-a, WAC 388-78A-2090-11-b, WAC 388-78A-2090-11-c

The Department staff who did the on-site verification:
Pamela Horlick, NCI RN Complaint Investigator

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

Sincerely,

Clinton Fridley RN

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 07/23/2025 of:

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

This document references the following SOD dated: 07/23/2025

The following sample was selected for review during the unannounced on-site visit: 3 of 50 current residents and 0 former residents.

The department staff that inspected 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

Statement of Deficiencies	License #: 2660	Compliance Determination #:623995
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 2 of 8	Licensee: Greenlake Management Lacey, LLC	07/23/2025

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

08/04/2025
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)

August 06, 2025
Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete an initial negotiated service agreement (NSA) after a resident moved to the community for 1 of 3 residents (Resident 1[R1]). This failure placed R1 at risk for unmet care needs and a decreased quality of life.

Findings include...

Record review of the facility policy, titled, "Resident Service Plans (See Negotiated Service Agreement"), revised on 02/15/2024, showed that based on the initial

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-2130 Service agreement planning. The assisted living facility must:

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(b) Identifies the resident's immediate needs; and

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This requirement was not met as evidenced by:

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Findings included…

Record review of the facility policy, titled, “Resident Service Plans (See Negotiated Service Agreement”), revised on 02/15/2024, showed that based on the initial

evaluation conducted prior to admission, an initial Service Plan will be developed. The initial Service Plan will be reviewed according to state regulations which are 14 days, 30 days and then annually or at change of condition.

Record review of facility document, “Plan of Correction”, had a compliance date of 06/18/2025. This document showed that the Health Services Director (Staff C) and Clinical Support Specialist (Staff A) were assigned to each lodge. DO (Director of Operations) was to ensure that Staff C was following policy with new admits and Staff A was to track in YARDI (computer program used for tracking care plans) for compliance. Staff C was to tend to the task with DO oversight for each move in.

Record review of facility document in-service sign in sheet titled, “Service Planning,” dated 05/29/2025, was signed by Staff A and Staff C that they received training on updating the service plan on day of move in and as needed and that they were to follow the facility’s policy and procedures.

Review of R1’s face sheet, dated 07/23/2025, showed that R1 was admitted to the facility on [redacted]/2024.

In a records request for R1’s initial NSA, one was not provided.

Review of R2’s face sheet, dated 07/23/2025, showed that R2 was admitted to the facility on [redacted]/2024.

In a records request for R2’s initial NSA, one was not provided.

In an interview on 07/23/2025 at 11:13AM, Staff A, Clinical Support Specialist, stated initial service plans were not completed for R1 or R2. Staff A stated it wasn’t triggered in the system to do an initial service plan. Staff A stated they would have done the initial service plan the day the residents moved into the facility. Staff A stated R1’s should have been completed on 06/23/2025 and R2’s should have been completed on 06/24/2025. Staff A was asked who was responsible for completing the NSA’s, they stated they were and the Health Services Director (HSD).

In a joint interview on 07/23/2025 at 12:54PM, Staff B, Business Office Manager and Staff A stated nothing was triggered in the system to complete the NSA. R1’s NSA should have been completed by 07/07/2025 and R2’s NSA should have been completed by 07/08/2025. Staff A stated we missed it.

In an interview on 07/23/2025 at 1:28PM, Staff C, Health Services Director, stated the initial NSA should be completed within 14 days of the resident being admitted to the facility. Staff C stated they typically do it the day the resident admits to the facility. Staff C stated they and the Executive Director were responsible for ensuring the care

Statement of Deficiencies	License #: 2600	Compliance Determination #:629985
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 4 of 8	Licensee: Greenlake Management Lacey, LLC	07/23/2025

plan was done on time.

This is an uncorrected deficiency previously cited on 05/21/2025.

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) 09-01-2025.

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

Administrator (or Representative) August 06, 2025 Date

WAC 388-78A-2080 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her;

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

plan was done on time.

This is an uncorrected deficiency previously cited on 05/21/2025.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the assisted living facility.

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete an initial assessment within 14 days after a resident moved to the community for 1 of 2 residents (Resident 1[R1]). This failure placed R1 at risk for unmet care needs and a decreased quality of life.

Findings included…

Record review of the facility policy, titled, “Accepting and Retaining Residents,” dated 02/15/2024, showed, “To ensure residents seeking move in are evaluated in a manner that is consistent with WAC 388-78A-2050 through WAC 388-78A-2090 and that prior to moving in, the community has determined that it has the ability to meet the identified needs and potential additional needs based on the residents risk factors identified during the initial move in evaluation.”

Record review of facility document, “Plan of Correction”, had a compliance date of 06/18/2025. This document showed that the Health Services Director (HSD) (Staff C) and Clinical Support Specialist (Staff A) were assigned to each lodge. All assessments would be inputted prior to the admit date unless it is an emergency admit, then the HSD would have 24 hours to input. Staff C was to follow the steps above along with the facility policy and procedure. HSD was to tend to task with DO (Director of Operations) oversight.

Record review of facility document Inservice sign in sheet, “Assessment Topics,” dated 05/29/2025, stated “To be done at admit, 14-day, 30 day and quarterly or change in condition,” and was signed by Staff A and Staff C that they received training when an assessment needs to be completed.

Review of R1’s face sheet, dated 07/23/2025, showed that R1 was admitted to the

facility on [redacted]/2024.

In a records request for R1's initial assessment, one was not provided.

Review of R2's face sheet, dated 07/23/2025, showed that R2 was admitted to the facility on [redacted]/2024.

In a records request for R2's initial assessment, one was not provided.

In an interview on 07/23/2025 at 11:13AM, Staff A, Clinical Support Specialist, stated pre-move in assessments were done for R1 and for R2 but initial assessments were not. Staff A was asked who was responsible for completing the assessments, they stated they were and the Health Services Director (Staff C). Staff A stated it should have been done. Staff A stated 14-day assessments were not completed. Staff A stated the system did not trigger them to do a 14-day assessment.

In an interview on 07/23/2025 at 12:54PM, Staff B, Business Office Manager, stated once the resident moves into the facility they should have done another assessment.

In an interview on 07/23/2025 at 1:28PM, Staff C was asked what the process was when a resident moves into the community, they stated they would do a preassessment prior to the resident moving to the facility, once that was completed they would do a move in assessment. Staff C stated the move in assessment was the initial assessment/14-day assessment. Staff C stated the assessment would then generate the care plan. Staff C stated the initial assessment would be completed within 14 days of the resident being admitted to the facility. Staff C was asked who was responsible for ensuring the assessments were completed on time, they stated them and the Executive Director.

This is an uncorrected deficiency previously cited on 05/21/2025.

Statement of Deficiencies	License #: 2600	Compliance Determination #:62986
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 8 of 8	License: Greenlake Management Lacey, LLC	07/23/2025

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) 09-01-2025 .

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

Administrator (or Representative) August 06, 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: 174303
Compliance Determination #: 58041
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 04/16/2025 through 05/21/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment and Resident/Patient/Client Rights: Report of resident not receiving care for a wound.
2. Quality of Life: Report of resident not receiving care and services.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 8 Closed records sample size: 1
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Guardian
Record Reviews:	State reporting log Facility policies Assessment CarePlan Progress Notes Disclosure of Services Medication Administration Record (MAR)

Investigation Summary:

Onsite investigation conducted. The concerns related to 1) Quality of Care 2.) Quality of Life, 3. Resident Rights were reviewed. The facility failed to ensure that the resident was assessed and develop a care plan to address resident needs.

Conclusion / Action:

☒ 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: 174700
Compliance Determination #: 58041
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 04/16/2025 through 05/21/2025
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Report of residents not receiving care and services and concern related to staffing.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 8 Closed records sample size: 1
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Guardian
Record Reviews:	State reporting log Facility policies Assessment CarePlan Progress Notes Disclosure of Services Medication Administration Record (MAR)

Investigation Summary:
Quality of Care/Treatment: Based on interview and record review, unable to substantiate care and services not being met. Staffing concern already investigated under statement of deficiency dated 4/18/2025.

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 04/16/2025 and 05/21/2025 of:

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

This document references the following complaint number(s): 174303, 174700

The following sample was selected for review during the unannounced on-site visit: 8 of 45 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

Statement of Deficiencies	License #: 2600	Compliance Determination # 58041
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 2 of 10	Licensee: Greenlake Management Lacey, LLC	05/21/2025

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

05/28/2025
Date

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

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

May 29, 2025
Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to complete an initial negotiated service agreement (NSA) after a resident moved to the community for 1 of 3 residents (Resident 1[R1]). This failure placed R1 at risk for unmet care needs and a decreased quality of life.

Findings included...

Record review of the facility policy, titled, "Resident Service Plans (See Negotiated Service Agreement"), last revised on 02/16/2024, stated, "An individualized Service

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-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

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Findings included…

Record review of the facility policy, titled, “Resident Service Plans (See Negotiated Service Agreement”), last revised on 02/15/2024, stated, “An individualized Service

Plan, addressing the needs and preferences identified during the initial evaluation and Life Story submission will be completed for each resident, prior to admission in accordance with WAC 388-78A-2130.
• An interdisciplinary approach will be utilized in developing the plan to ensure that the plan addresses the personal care, nursing, dietary, activity, mental, emotional and environmental needs of the resident.
• Re-evaluation will ensure that the Community can continue to meet the changing needs of the resident.
• The resident and representative/family members will be encouraged to participate in the plan development as well.
• The plan will be reviewed prior to admission and thereafter annually with the resident, family and/or responsible party at a care conference."

Under the section titled, "Procedure," showed, "Based on the initial evaluation conducted prior to admission, an initial Service Plan will be developed. The initial Service Plan will be reviewed according to state regulation which are 14 days, 30 days and then annually or at change of condition."

Review of R1's face sheet, dated 04/16/2025, showed that R1 was admitted to the facility on [redacted]/2024.

Review of Department Records showed that a report was received on 04/07/2025 at 11:13AM notifying the Department that R1 had not been receiving care needed for an ankle wound, activities of daily living or receiving medical attention. R1 was found to have been weak, more confused, wearing layered clothing and needed to be showered. The facility failed to communicate or hold a care plan for R1. R1 had been transferred to the hospital due to change in medical conditions and concerns with the ankle wound. Infection was detected with hospital admission. The wound not being properly cared for at the facility R1.

Record review of a letter, titled, "Pre-Assessment for [facility]," dated 09/24/2024, showed R1 "has dry skin and left leg has discoloration and redness. Left Malleolus [the rounded bony prominence located at the ankle joint] has a stage 2 ulcer (a type of skin damage that results from prolonged pressure on a specific area of the body) that is chronic. Needs wound care. High risk for infection."

Record review of R1's "Washington Resident Assessment (facility's preadmission assessment)," dated 09/24/2024, under "Chronic Skin Condition (Current or Potential) showed "Left malleolus ulcer, needs wound care." Under "Special Care," showed, "Wound Care."

Record review of R1's record showed there was no negotiated service agreement to inform staff of R1's care needs completed or available for review.

In an interview on 04/16/2025 at 11:22 AM, Staff B, Health and Wellness Director, stated they had sent a referral for wound care for R1. Staff B stated that was the only note. Staff B was asked if they kept wound care notes, they stated no, it was done outside the facility. The company that did the wound care kept their own notes. Staff B stated R1 didn't have a care plan. Staff B stated there was nothing in the system for R1. Staff B was asked how staff were to know how to care for R1, they stated based off the DSHS (Department of Social and Health Services) report and the admission assessment. Staff B was asked who was responsible to ensure the care plan was done and signed, they stated it was their responsibility. Staff B was asked if a resident moved out to another facility if they would send the current care plan to where the resident was moving to, they stated, yes, if they had one. Staff B stated, R1 didn't have a care plan.

Record review of R1's progress notes, dated 03/06/2025, showed, Staff B reached out to home health regarding wound care referral. Home health is to reach out. No other notes documented before or after 03/06/2025.

In an interview on 04/16/2025 at 2:52 PM, Staff B stated they faxed the company that did R1's wound care to request wound care notes for R1. Staff B stated they will send it over to the department when they receive them. As of 05/21/2025 wound care records were never received by the department.

In an interview on 04/16/2025 at 3:41 PM, Staff B was asked when they would do a care plan for a resident, they stated the assessment generated the care plan. Staff B stated there was an initial care plan, a 14 day care plan and quarterly care plan done. Staff B was asked why R1 didn't have a care plan, they stated they got back logged and were working the floor. Staff B stated they just missed it.

Refer to Washington Administrative Code 388-78A-2090.

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)

May 29th, 2025
Date

In an interview on 04/16/2025 at 11:22 AM, Staff B, Health and Wellness Director, stated they had sent a referral for wound care for R1. Staff B stated that was the only note. Staff B was asked if they kept wound care notes, they stated no, it was done outside the facility. The company that did the wound care kept their own notes. Staff B stated R1 didn't have a care plan. Staff B stated there was nothing in the system for R1. Staff B was asked how staff were to know how to care for R1, they stated based off the DSHS (Department of Social and Health Services) report and the admission assessment. Staff B was asked who was responsible to ensure the care plan was done and signed, they stated it was their responsibility. Staff B was asked if a resident moved out to another facility if they would send the current care plan to where the resident was moving to, they stated, yes, if they had one. Staff B stated, R1 didn't have a care plan.

Record review of R1's progress notes, dated 03/06/2025, showed, Staff B reached out to home health regarding wound care referral. Home health is to reach out. No other notes documented before or after 03/06/2025.

In an interview on 04/16/2025 at 2:52 PM, Staff B stated they faxed the company that did R1's wound care to request wound care notes for R1. Staff B stated they will send it over to the department when they receive them. As of 05/21/2025 wound care records were never received by the department.

In an interview on 04/16/2025 at 3:41 PM, Staff B was asked when they would do a care plan for a resident, they stated the assessment generated the care plan. Staff B stated there was an initial care plan, a 14 day care plan and quarterly care plan done. Staff B was asked why R1 didn't have a care plan, they stated they got back logged and were working the floor. Staff B stated they just missed it.

Refer to Washington Administrative Code 388-78A-2090.

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Administrator (or Representative) Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the assisted living facility.

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to complete an initial assessment after a resident moved to the community for 1 of 2 residents (Resident 1

[R1]). This failure placed R1 at risk for unmet care needs and a decreased quality of life.

Findings included…

Record review of the facility policy, titled, “Accepting and Retaining Residents,” dated 02/15/2024, showed, “To ensure residents seeking move in are evaluated in a manner that is consistent with WAC 388-78A-2050 through WAC 388-78A-2090 and that prior to moving in, the community has determined that it has the ability to meet the identified needs and potential additional needs based on the residents risk factors identified during the initial move in evaluation. It is the purpose of this Community to provide a quality living environment for residents whose medical status is stable and predictable and may require assistance with personal care, intermittent nursing, monitoring and supervision, but who do not require 24-hour skilled nursing.”

Review of Department Records showed that a report was received on 04/07/2025 at 11:13AM notifying the Department that R1 had not been receiving care needed for an ankle wound, activities of daily living or receiving medical attention. R1 was found to have been weak, more confused, wearing layered clothing and needed to be showered. The facility failed to communicate or hold a care plan for R1. R1 had been transferred to the hospital due to change in medical conditions and concerns with the ankle wound. Infection was detected with hospital admission. The wound not being properly cared for at the facility.

Review of R1’s face sheet, dated 04/16/2025, showed that R1 was admitted to the facility on [redacted]/2024.

Record review of R1’s Washington Resident Assessment (preadmission assessment), dated 09/24/2024, showed R1 had a left malleolus ulcer (a type of open sore that develops on the lower leg, just above the ankle) that needed wound care. There were no other assessments completed or available for review.

Review of R1’s record showed there was no negotiated service agreement to inform staff of R1’s care needs.

In an interview on 04/16/2025 at 3:41 PM, Staff B, Health and Wellness Director, was asked when they would do a care plan for a resident, they stated the residents assessment generated the care plan (NSA).

In an interview on 05/20/2025 at 3:34PM, Staff B stated a preassessment was done before the resident gets to the facility. Staff B stated then once they arrive to the facility they were to complete a 14 day assessment, a 30-day assessment and then a quarterly assessment. Staff B was asked if R1 had an initial assessment completed, they stated, no, one was not done for R1.

Statement of Deficiencies	License #: 2600	Compliance Determination # 58041
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 8 of 10	Licensee: Greenlake Management Lacey, LLC	05/21/2025

Refer to Washington Administrative Code 388-78A-2130.

Plan/Attestation Statement

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Director of Operations

Patricia Santos-Love

Administrator (or Representative)

May 29, 2025

Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide appropriate infection control supplies for 4 of 4 residents rooms (Resident 4, Resident 5, Resident 6, and Resident 7) reviewed. This failure placed 45 of 45 residents and staff at risk of spreading infectious diseases.

Findings included...

Review of the facility policy, titled, "Supplemental Infection Prevention and Control Program," dated 02/15/2024, showed, "This community maintains an organized program designed to systematically identify and reduce the risk of acquiring and transmitting infections among residents, visitors and healthcare workers. This program involves the collaboration of leadership, staff and residents and is destined to meet the intent of regulatory agencies and promote the well-being of staff and residents." Under the section titled, Infection Prevention Goals," showed, " All staff and leadership work as a team to enhance infection control efforts for all who live, work in or visit the community.

Refer to Washington Administrative Code 388-78A-2130.

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide appropriate infection control supplies for 4 of 4 residents rooms (Resident 4, Resident 5, Resident 6, and Resident 7) reviewed. This failure placed 45 of 45 residents and staff at risk of spreading infectious diseases.

Findings included…

Review of the facility policy, titled, “Supplemental Infection Prevention and Control Program,” dated 02/15/2024, showed, “This community maintains an organized program designed to systematically identify and reduce the risk of acquiring and transmitting infections among residents, visitors and healthcare workers. This program involves the collaboration of leadership, staff and residents and is destined to meet the intent of regulatory agencies and promote the well-being of staff and residents.” Under the section titled, Infection Prevention Goals,” showed, “ All staff and leadership work as a team to enhance infection control efforts for all who live, work in or visit the community.

Goal: Limit employee, resident, and visitor unprotected exposure to pathogens
Goal: Limiting the transmission of infections associated with resident care.
Goal: Limiting the transmission of infections associated with the use of medical equipment, devices and supplies;
Goal: Enhancing hand hygiene."
Under the section titled, "Actions to support infection prevention goals," showed, "Follow CDC/DOH [Centers for Disease Control and Prevention/Department of Health] guidelines for hand hygiene."

Record review of CDC's document titled, "Clinical Safety: Hand Hygiene for Healthcare Workers", dated 02/27/2024, showed hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with water and soap, antiseptic hand rub (alcohol-based foam or gel hand sanitizer), or surgical hand antisepsis. CDC provides the following recommendations for hand hygiene in healthcare settings that include to clean your hands immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces, immediately after glove removal. Unless if hands were visibly soiled, alcohol based hand sanitizer was to be used in most clinical situations. CDC recommended to wash your hands with soap and water when they were visibly soiled, before eating, after using the restroom, and during the care of a patient with a suspected or confirmed infection during outbreaks of norovirus (a virus that causes inflammation in the stomach and colon that causes vomiting and diarrhea) or clostridium difficile (a bacterium in the colon that causes inflammation, infection and watery stools). Under the section titled, "when to wear gloves", showed glove use falls under standard precautions (when you anticipate that you will come in contact with blood or other infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment).

In an observation and interview on 04/16/2025 at 7:13AM, Staff D, Caregiver, took a resident to the restroom after putting gloves on. After the resident used the toilet, Staff D removed their gloves and pushed the soap dispenser. No soap was observed in the dispenser. Staff D stated there was no soap in the dispenser and needed to step out and wash her hands. Staff D opened the door with their unwashed hands to exit the room. Staff D observed to their wash hands at the sink in common area.

In an observation and interview on 04/16/2025 at 10:14AM, Staff E, Caregiver, was asked where they would wash their hands at after providing care to a resident, they stated in the residents room or in the residents bathroom. Staff E was asked if there was soap in Resident 4's (R4) room, they stated no, there wasn't. The soap dispenser in the bathroom was empty. Staff E was asked what they did when there was no soap in the residents room, they stated they leave and wash their hands in the common area by the kitchen.

In an observation on 04/16/2025 at 10:29AM, the soap dispenser in Resident 5's (R5) bathroom was empty.

In an observation and interview on 04/16/2025 at 10:31AM, the soap dispenser in Resident 8's (R8) bathroom was empty. Staff E was asked where they had to go to wash their hands if there was no soap in the resident room, they stated they go to the common area by the kitchen, staff restroom or the medication technician room.

In an interview on 04/16/2025 at 10:38AM, Staff F, Caregiver, was asked where they would wash their hands at after providing care to a resident, they stated, they would wash their hands in the medication room, staff bathroom, or at the sink by the kitchen. Staff F was asked why they didn't wash them in the residents room, they stated, there was no soap in the dispensers half the time. Staff F was asked if they notified anyone that there was no soap, they stated they had notified the medication technicians and the person that ordered the supplies.

In an observation and interview on 04/16/2025 at 2:25PM, Resident 7 (R7) was observed to be itching their left and right thigh. R7 stated that their back, head, and face itch. R7 observed to have scabs on left knee. R7 was observed trying to get soap out of the soap dispenser and none was dispensed. R7 was asked how they wash their hands, they stated they don't have any soap so they can't.

In an interview on 04/16/2025 at 3:41PM, Staff B, Health and Wellness Director, was asked if there should be hand washing supplies available for staff to use after performing care, Staff B stated yes, the supplies would be at the sink or bathroom.

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Director of Operations

Patricia Santos-Love

Administrator (or Representative)

May 29, 2025

Date

In an observation and interview on 04/16/2025 at 10:31AM, the soap dispenser in Resident 6's (R6) bathroom was empty. Staff E was asked where they had to go to wash their hands if there was no soap in the resident room, they stated they go to the common area by the kitchen, staff restroom or the medication technician room.

In an interview on 04/16/2025 at 10:38AM, Staff F, Caregiver, was asked where they would wash their hands at after providing care to a resident, they stated, they would wash their hands in the medication room, staff bathroom, or at the sink by the kitchen. Staff F was asked why they didn't wash them in the residents room, they stated, there was no soap in the dispensers half the time. Staff F was asked if they notified anyone that there was no soap, they stated they had notified the medication technicians and the person that ordered the supplies.

In an observation and interview on 04/16/2025 at 2:25PM, Resident 7 (R7) was observed to be itching their left and right thigh. R7 stated that their back, head, and face itch. R7 observed to have scabs on left knee. R7 was observed trying to get soap out of the soap dispenser and none was dispensed. R7 was asked how they wash their hands, they stated they don't have any soap so they can't.

In an interview on 04/16/2025 at 3:41PM, Staff B, Health and Wellness Director, was asked if there should be hand washing supplies available for staff to use after performing care, Staff B stated yes, the supplies would be at the sink or bathroom.

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