STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 80945 (Completion Date 07/23/2026) and 77927 (Completion Date 05/28/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/23/2026 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-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, WAC 388-78A-2610-1, WAC 388-78A-2610-2-d, WAC 388-78A-2610-2-e, WAC 388-78A-2610-2-c-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2, WAC 388-78A-2474-2-e, WAC 388-78A-2474-3

The Department staff who did the on-site verification:
Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

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

This document was prepared by Residential Care Services for the Locator website.

Sincerely,

Cory Cisneros

Cory Cisneros, Nursing Home Allied Health Field Manager
Region 3, Unit E
Residential Care Services

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STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING 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 05/26/2026 and 05/28/2026 of:

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

This document references the following SOD dated: 05/28/2026

The following sample was selected for review during the unannounced on-site visit: 4 of 47 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Celeste Vashey, ALF LTC Licensor
Anissa Bearden, Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2600	Compliance Determination # 77927
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 2 of 16	Licensee: Greenlake Management Lacey, LLC	05/28/2026

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, RN
Residential Care Services

06/09/2026
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.

Jodi M Stephens
Administrator (or Representative)

6/12/2026
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

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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

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Administrator (or Representative) | Date

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

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(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;

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(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

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(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.

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(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 ensure a 14-day assessment was completed for 2 of 2 residents (Resident 1 and 2). This failure placed both residents at risk of having unmet care needs.

Findings included…

Record review of the facility's policy titled "Evaluations," undated, showed evaluations were completed to determine the level of assistance required to maximize each residents quality of life and were to be completed prior to admission and then on the day of move-in.

Resident 1 (R1)

Record review of R1's medical records showed they moved into the facility on [redacted]/2026.

Record review of the facility provided medical records for R1 showed there was no 14-day assessment completed.

Resident 2 (R2)

Record review of R2's medical records showed they moved into the facility on [redacted]/2026.

Record review of the facility provided medical records for R2 showed there was no 14-day assessment completed.

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Record review of an email sent to the Department on 05/26/2026 at 5:59 PM, showed they were unaware that 14-day assessments were not completed after a new resident moved into to the facility.

In an interview on 05/28/2026 at 9:55 AM, Staff B, Health Services Director, stated there was confusion on the expectation of when 14-day assessments were to be completed, which was why R1 and R2 did not have any completed assessments to review.

This is an uncorrected deficiency previously cited on 04/07/2026 and recurring deficiency previously cited on 07/23/2025 and 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) July 10, 2026

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

Jodine Stephens

Administrator (or Representative) Date 6/12/26

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) Maintain and provide staff persons with the necessary training, supplies, equipment, and personal protective equipment for preventing and controlling the spread of infections by:

(ii) Ordering supplies when necessary.

(d) Provide all resident care and services according to current acceptable standards for infection control;

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure staff performed hand hygiene during resident care for 2 of 2 staff observed (Staff H and G),

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Record review of an email sent to the Department on 05/26/2026 at 5:59 PM, showed they were unaware that 14-day assessments were not completed after a new resident moved into to the facility.

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Administrator (or Representative) Date

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(ii) Ordering supplies when necessary.

(d) Provide all resident care and services according to current acceptable standards for infection control;

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure staff performed hand hygiene during resident care for 2 of 2 staff observed (Staff H and G),

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failed to provide necessary handwashing supplies in 4 of 4 resident care areas observed (Lodge 1 soiled laundry room, Lodge 2 soiled laundry room, Lodge 1 dining room and Resident 13's bathroom), failed to ensure staff implemented appropriate infection control practices to keep clean and soiled laundry separated for 1 of 2 Lodges (Lodge 1). These failures placed all residents, staff and visitors at risk for infectious disease or illness.

Findings included…

Record review of the facility's policy titled "Supplemental Infection Prevention and Control Program," dated 02/15/2024, documented the program was overseen by the executive director and the health services director. Actions to support infection prevention goals included follow the Centers for Disease Control (CDC) and Department of Health (DOH) guidelines for hand hygiene. Resident care and services were conducted according to current acceptable standards for infection control. Housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control.

Hand Hygiene and Laundry Room

Washington Administrative Code 388-78A-3040 Laundry. "(1) The assisted living facility must provide laundry and linen services on the premises, or by commercial laundry. (2) The assisted living facility must handle, clean, and store linen according to acceptable methods of infection control. The assisted living facility must: (a) Provide separate areas for handling clean laundry and soiled laundry; (b) Ensure clean laundry is not processed in, and does not pass through, areas where soiled laundry is handled."

Record review of the facility's policy infection control standard precautions, 02/15/2024, documented employees were to assume that all bodily fluids except sweat may contain transmissible infectious agents and required them to use standard precautions.

Lodge 1 Public Bathroom

In an observation on 05/26/2026 at 9:42 AM the public resident bathroom showed there were no paper towels inside of the paper towel receptacle or anywhere else in the bathroom.

Lodge 1 Laundry Room

In an observation on 05/26/2026 at 9:57 AM, the laundry room's hand-washing sink showed there were no paper towels inside of the paper towel receptacle or anywhere else in the vicinity.

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In an observation and interview on 05/26/2026 at 9:57 AM, Staff F, Caregiver, was inside of the laundry room and looked at the hand-washing sink and confirmed there were no paper towels accessible to use.

In an interview on 05/26/2026 at 9:59 AM, Staff C, Housekeeping, stated they were responsible for stocking paper towels inside of the facility.

In an observation on 05/26/2026 at 10:05 AM, Staff H, Caregiver, entered the soiled side of the laundry room while they carried a clear garbage bag and threw the item away. Staff H was observed to start the hand-washing process; there were no paper towels accessible for them to use. With their wet hands Staff H touched the soiled side of the laundry room doorknob to exit the area.

In an observation and interview on 05/26/2026 at 10:15 AM, Staff H entered the soiled side of the laundry room. Staff H was observed to start the hand-washing process; there were no paper towels accessible for them to use. Staff H confirmed there were no paper towels accessible for them to use. With their wet hands Staff H touched the soiled side of the laundry room doorknob to exit the area.

Lodge 2 Laundry Room

In an observation on 05/26/2026 at 9:56 AM, the laundry room by the hand-washing sink there was a paper towel dispenser on the wall that was empty. There were no other paper towels available in the area to use.

Lodge 2 Dining Room

In an observation on 05/26/2026 at 11:32 AM, Staff G, Caregiver, wore disposable gloves on both hands passing out cups full of juice and water to the residents. At 11:35 AM, Staff G picked up Resident 7's silverware on the ground, discarded it in the kitchen, removed their gloves, grabbed clean silverware and handed it to another female resident. There was no hand hygiene observed performed.

In an observation on 05/26/2026 at 11:36 AM, Staff G pulled Resident 6's (R6) dining room chair and touched their shoulders to guide them to the chair. Staff G then redirected Resident 4 (R4) to sit back down and grabbed clean silverware and napkin and provided it to R6. There was no hand hygiene observed performed.

In an observation on 05/26/2026 at 11:41 AM, Staff G was touching a clip board with a paper and then grabbed two plates of ready to eat food and handed the plates to the residents. Staff G then assisted a female resident from Lodge 1 to sit down at a dining room table. Staff G grabbed two more ready to eat plates of food and passed them out

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to R4 and another resident. Staff G continued to pass out plates of ready to eat food without performing hand hygiene.

In an observation on 05/26/2026 for times 11:32 AM through 11:56 AM, Staff G was not observed to perform hand hygiene after changing from one task to another task.

In an interview on 05/26/2026 at 12:48 PM, Staff G stated they were to wash their hands with soap and water or use hand sanitizer solution before and after use of gloves and anytime they changed a task. Staff G stated they did not have any hand sanitizer on their key ring or on them to use.

This is an uncorrected deficiency previously cited on 04/07/2026 and recurring deficiency previously cited on 05/21/2025.

Plan/Attestation Statement

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

Jackie Stephens

Administrator (or Representative) Date 6/12/2026

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document in the resident's Washington Health and Service Evaluation Results and Service Plan (facility's version of the Negotiated Service Agreement [NSA]) the plan to provide assistance with activities of daily living (ADLs), the residents' preferences on how services would be provided and updates to the plans related to incidents or injuries for 4 of 4 sampled

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residents (Resident 1, 2, 3 and 4). These failures placed the residents at risk for unmet care needs and care and services not being provided per the NSA.

Findings included…

Record review of the facility's policy titled “Negotiated Service Agreement,” dated 02/15/2024, documented the service plan would contain a description and clearly define respective roles and responsibilities related to the resident’s care and service needs. The policy documented that the description should include a plan to monitor and provide interventions for current risks to the residents’ health and safety identified in resident assessments, include how and when activities of daily living needs would be met and how the resident’s preferences would be honored. The policy documented that the NSA would include frequency and approximate time of day the outlined services would be provided.

Record review of the facility’s policy titled “Temporary Service Plans,” dated 02/14/2025, documented each time there was a change in a resident’s care approach, an appropriate temporary service plan (TSP) form would be completed, and all caregivers were responsible to read and sign the TSP. A TSP was to be completed each time there was a care approach change for a resident. Staff were to follow the approaches as specified on the residents’ TSP’s.

Record review of the facility’s policy titled “Change of Condition,” dated 09/24/2024, documented the medication technician, resident care coordinator or the Health Service Director would determine the type of intervention and if follow-up was indicated. Any nursing interventions or new physician orders implemented would be documented on the TSP.

Resident 1 (R1)

Record review of R1’s medical records showed they moved into the facility on [redacted]/2026.

Showers

Record review of R1’s NSA, dated 05/22/2026, showed R1 required minimal assistance with showering. There were no specific days listed when R1 was to receive their showers.

Housekeeping

Record review of R1’s NSA, dated 05/22/2026, showed R1 was dependent on staff to

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complete their housekeeping services. There were no specific days or times listed when R1's housekeeping was provided.

Resident 2 (R2)

Record review of R2's medical records showed they moved into the facility on [redacted]/2026.

Diet

Record review of R2's NSA, dated 05/22/2026, showed R2 was on a regular diet.

Record review of R2's Move-In Orders, dated 04/24/2026, showed R2 was to have a low salt mechanical soft texture diet and pudding thick liquids.

In an observation on 05/26/2026 at 12:05 PM, R2 was brought their meal tray that had two cups of pudding thick yellow juice and a plate of mechanical soft roast beef delivered to them in their room.

Showers

Record review of R2's NSA, dated 05/22/2026, showed R2 required moderate assistance with showering. There were no specific days or times listed when R2 was to receive their showers.

Housekeeping

Record review of R2's NSA, dated 05/22/2026, showed R2 was dependent on staff to complete their housekeeping services. There were no specific days or times listed when R2's housekeeping was provided.

Cognitive

Record review of R2's NSA, dated 05/22/2026, showed R2 did not have any sensory impairments or used communication enabling devices. There was no documentation that R2 did not talk or rarely verbalized their needs.

In an interview on 05/26/2026 at 12:01 PM, Staff E, Medication Technician, stated since R2 admitted to the facility they really do not talk.

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In an interview on 05/28/2026 at 10:26 AM, Staff E stated R2 ate mechanical soft texture food and pudding thickened liquids. Staff E stated R2 rarely talked and required the staff to provide total care for them.

In an interview on 05/28/2026 at 10:36 AM, Staff B, Health Services Director, stated R2's diet texture, liquid consistency and that R2 does not talk much should be incorporated in the NSA.

Resident 3 (R3)

Record review of R3's medical records showed they moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted].

Showers

Record review of R3's NSA, dated 12/30/2026, showed it was updated on 02/02/2026. R3 required extensive staff assistance with their showering. There were no specific days or times listed when R4 was to receive their showers.

In an interview on 05/26/2026 at 10:06 AM, R3 stated they were to get their showers on Tuesdays and Saturdays.

Housekeeping

Record review of R3's NSA, dated 12/30/2026, showed R3 was dependent on staff to complete their housekeeping services. There were no specific days or times listed when R2's housekeeping was provided.

Skin

Record review of R3's NSA, dated 12/30/2026, showed R3 had a pressure ulcer and irritation on their skin. The NSA did not say where the skin condition was located.

Record review of R3's Nurse Delegation Nursing visit document, dated 05/09/2026, showed they had open skin areas on both buttock cheeks that required staff to provide increase incontinent care, repositioning and application of prescribed cream to the area.

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Resident 4 (R4)

Record review of R4's medical records showed they moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted].

Showers

Record review of R4's NSA, dated 02/02/2026, showed R4 required extensive assistance from staff with bathing. There were no specific days or times listed when R4 was to receive their showers.

Housekeeping

Record review of R4's NSA, dated 02/02/2026, showed R4 was dependent on staff to complete their housekeeping services. There were no specific days or times listed when R4's housekeeping was provided.

In an interview on 05/28/2026 at 9:57 AM, Staff B stated when they update the residents NSA's they try to put the residents shower days on their, diet texture and liquid consistency if different from thin. Staff B stated they had not been incorporating the residents' housekeeping days on the NSA.

This is an uncorrected deficiency previously cited on 04/07/2026.

Plan/Attestation Statement

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

Jodine Stephens — Administrator (or Representative)

6/12/2026 — Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

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Resident 4 (R4)

Record review of R4's medical records showed they moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted].

Showers

Record review of R4's NSA, dated 02/02/2026, showed R4 required extensive assistance from staff with bathing. There were no specific days or times listed when R4 was to receive their showers.

Housekeeping

Record review of R4's NSA, dated 02/02/2026, showed R4 was dependent on staff to complete their housekeeping services. There were no specific days or times listed when R4's housekeeping was provided.

In an interview on 05/28/2026 at 9:57 AM, Staff B stated when they update the residents NSA's they try to put the residents shower days on their, diet texture and liquid consistency if different from thin. Staff B stated they had not been incorporating the residents' housekeeping days on the NSA.

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

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(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff received all required Tuberculosis (infectious bacterial disease of the lungs) testing within the required time frames for 1 of 2 sampled Staff (Staff K). This failure resulted in the facility failing to test staff for Tuberculosis (TB) and placed all residents, staff and visitors at risk for exposure to highly communicable disease.

Findings included…

Record review of the facility's undated policy titled "Tuberculosis Screening and Testing for Staff" documented that the facility was to ensure that all staff were screened for TB within three days of hire. If a staff member required TB testing, they either completed a TB skin test or blood test based upon the screening results. A two-step TB test included the first test within three days of hire and the second test to be administered one to three weeks after the first test was administered.

Record review of the untitled and undated document list of employees showed Staff K, Caregiver, started employment on 05/13/2026.

Record review of Staff K's TB test documentation form, undated, showed they had their first step TB skin test on 05/20/2026.

In an interview on 05/28/2026 at 9:39 AM, Staff A, Executive Director, stated Staff K's first step TB skin test was not completed within three days of Staff K's date of hire on 05/13/2026.

This is an uncorrected deficiency previously cited on 04/07/2026 for subsection 388-78a-2484(1).

This document was prepared by Residential Care Services for the Locator website.

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) July 10, 2024

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

Jodine Stephens
Administrator (or Representative)

6/12/2024
Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 2 sampled staff (Staff I) had their food worker's card and the facility failed to ensure 2 of 2 sampled staff (Staff C and F) knew the process on mandated reporting. These failures placed all residents at risk of being improperly cared for by untrained staff.

Findings included...

Record review of the facility's document titled "New Employee Orientation," undated, documented the administrative orientation had a topic section on abuse reporting. The resident care orientation had a topic on characteristics and needs of the residents. The position specific orientation had a topic that included food handler's permit.

Food Worker's Card

Washington Administrative Code (WAC) 246-217-015 (1) "(1) All food service workers must obtain a food worker card within fourteen calendar days from the beginning of employment at a food service establishment, except as provided in subsection (4) of this section."

This document was prepared by Residential Care Services for the Locator website.

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-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 1 of 2 sampled staff (Staff I) had their food worker's card and the facility failed to ensure 2 of 2 sampled staff (Staff C and F) knew the process on mandated reporting. These failures placed all residents at risk of being improperly cared for by untrained staff.

Findings included…

Record review of the facility's document titled "New Employee Orientation," undated, documented the administrative orientation had a topic section on abuse reporting. The resident care orientation had a topic on characteristics and needs of the residents. The position specific orientation had a topic that included food handler's permit.

Food Worker's Card

Washington Administrative Code (WAC) 246-217-015 (1) "(1) All food service workers must obtain a food worker card within fourteen calendar days from the beginning of employment at a food service establishment, except as provided in subsection (4) of this section."

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WAC 246-217-035 “(5) The card shall be approximately three inches by five inches in size and contain the following information: (a) The identification of the card as a Washington state food worker card or "limited duty card," as applicable; (b) The identity of the jurisdictional health department issuing the card; (c) Printed (or typed written) name and signature of the food service worker; (d) Card expiration date; (e) Signature of the health officer; and (f) Any other identifier or other information deemed necessary by the health officer.”

Record review of the untitled and undated document list of employees showed Staff I, Caregiver, started employment on 04/27/2026.

Record review of Staff I employee records showed there was no Washington State Food workers card completed.

In an interview on 05/28/2026 at 10:41 AM, Staff A stated the business office manager and themselves were unaware that the food worker had to be a Washington state food worker card and Staff I did not have one completed.

Mandated Reporting

Record review of the facility’s policy titled “Abuse and Neglect-Resident,” dated 02/15/2024, documented all staff members would be educated about abuse and neglect in the assisted living setting. During orientation and annually the facility staff would be trained on mandatory reporting. Alleged abuse would be immediately reported by the person who witnessed it to the supervisor on duty, the administrator, and the appropriate state agency.

Record review of the facility’s In-Service Sign in Sheet, dated 02/09/2026, showed it was review of the mandatory reporting of abuse and neglect and all care staff were mandatory reporters.

Record review of the document attached to the facility’s In-Service titled “Mandatory Reporting of Abuse and Neglect,” undated, showed all mandatory reporters were legally required to report any reasonable suspicion of abuse, neglect, abandonment or exploitation of a vulnerable and make a report to the Washington state hotline number. Staff reporting to the supervisor does not meet the legal obligation of reporting as a mandatory reporter.

In an interview on 05/26/2026 at 9:59 AM, Staff C, Housekeeping, stated if they had concerns that a resident was being abused or neglected they would notify the facility’s executive director or nurse and if they did not follow up then they would report it to the state. Staff C was not aware where the hotline poster was in the facility. Staff C stated

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they would have no way of knowing if the executive director or nurse followed up and addressed the concern.

In an interview on 05/26/2026 at 12:10 PM, Staff F, Caregiver, stated if a resident was observed to be abused or neglected they would report to the medication technician on shift and then the nurse. Staff F stated the medication technician would make the report to the state hotline number of the allegation.

This is an uncorrected deficiency previously cited on 04/07/2026 for subsection 388-78a-2474(2)(e),(3).

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) July 10, 2026

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

Jodi M Stephens
Administrator (or Representative)

6/12/2026
Date

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they would have no way of knowing if the executive director or nurse followed up and addressed the concern.

In an interview on 05/26/2026 at 12:10 PM, Staff F, Caregiver, stated if a resident was observed to be abused or neglected they would report to the medication technician on shift and then the nurse. Staff F stated the medication technician would make the report to the state hotline number of the allegation.

This is an uncorrected deficiency previously cited on 04/07/2026 for subsection 388-78a-2474(2)(e),(3).

Plan/Attestation Statement

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

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

_____ _____

Administrator (or Representative) Date

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Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2600
Intake ID: 207831
Compliance Determination #: 72250
Region/Unit #: RCS Region 3 / Unit E
Investigator: Celeste Vashey
Investigation Date(s): 02/02/2026 through 04/07/2026
Complainant Contact Date(s):

Allegation(s):
Allegation of neglect which contributed to a residents death.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 7 Closed records sample size: 2
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Nursing staff Residents Family members
Record Reviews:	Medical records State reporting log Incident investigation Facility policies Personnel files Staff training records

Investigation Summary:
After observation, interview and record review the facility will be cited for WAC 388 78A 2660, WAC 388 78A 2320, WAC 388 78A 2140 and WAC 388 78A 2640.

Conclusion / Action:

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

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☐ N/A

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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 the unannounced on-site full inspection and complaint investigation on 02/02/2026 and 02/06/2026 of:

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

This document references the following complaint numbers: 207831.

The following sample was selected for review during the unannounced on-site visit: 7 of 47 current residents and 2 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor
Clinton Fridley, Community Nurse Field Manager

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

This document was prepared by Residential Care Services for the Locator website.

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, RN
Residential Care Services

04/16/2026
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.

Jodi M. Stephens
Administrator (or Representative)

4/17/2026
Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(3) Not use restraints on any resident;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(5) Provide care and services to each resident in compliance with applicable state statutes related to substitute health care decision making, including chapters 7.70 and 70.122 RCW;

(6) Reasonably accommodate residents consistent with applicable state and federal law;

(7) Not allow any staff person to abuse or neglect any resident; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to address and resolve resident grievances for 6 of 7 residents (Resident 17, 5, 3, 19, 4 and 7), failed to provide dignified care for 7 of 7 residents (Resident 7, 11, 1, 15, 2 and 25) and failed to protect resident confidential information for 4 of 4 residents (Resident 21, 23, 22 and 2). These failures resulted in residents having unresolved concerns, experienced increased pain, delay in medical care and placed residents at risk for decreased quality of life.

Findings included...

Revised Code Washington (RCW) 70.129.140 "Quality of life—Rights... (2) Within

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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-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(3) Not use restraints on any resident;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(5) Provide care and services to each resident in compliance with applicable state statutes related to substitute health care decision making, including chapters 7.70 and 70.122 RCW;

(6) Reasonably accommodate residents consistent with applicable state and federal law;

(7) Not allow any staff person to abuse or neglect any resident; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to address and resolve resident grievances for 6 of 7 residents (Resident 17, 5, 3, 19, 4 and 7), failed to provide dignified care for 7 of 7 residents (Resident 7, 11, 1, 15, 2 and 25) and failed to protect resident confidential information for 4 of 4 residents (Resident 21, 23, 22 and 2). These failures resulted in residents having unresolved concerns, experienced increased pain, delay in medical care and placed residents at risk for decreased quality of life.

Findings included…

Revised Code Washington (RCW) 70.129.140 “Quality of life—Rights… (2) Within

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reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to… (c) Make choices about aspects of his or her life in the facility that are significant to the resident; (d) Wear his or her own clothing and determine his or her own dress, hair style, or other personal effects according to individual preference;… (5) A resident has the right to: (b) Receive notice before the resident's room or roommate in the facility is changed."

Quality of Life

Resident 7 (R7)

Record review of R7's Washington Health and Service Evaluation Results and Service Plan, dated 01/25/2026, documented R7 moved into the facility on [redacted]/2014 with multiple medical diagnoses that included [redacted] and [redacted]. R7 required minimal assist with cues and prompts from staff to use their walker and transfers. R7 was to get a shower one to two times weekly. There was no specific preference days or approximate times listed.

Record review of R7's After Visit Summary, dated 01/30/2026, documented they were seen at the emergency department after a fall. R7's imaging of their left shoulder, documented they had a humeral neck fracture (upper arm broke at the head part by the shoulder). R7 was to keep their arm immobilized in a sling and use ice for pain management.

Record review of R7's progress note, dated 02/01/2026 at 5:12 AM, documented they refused to sleep in their room, complained of pain during their shift and was medicated that only reduced some of the pain.

Record review of R7's progress note, dated 02/01/2026 at 1:21 PM, documented they had a hard time lifting up both of their arms.

Record review of R7's progress note, dated 02/01/2026 at 9:36 PM, documented that they were uncomfortable and complained of the in their shoulder after they had taken pain medication.

An observation on 02/02/2026 at 11:50 AM, showed R7 sitting at a center table, in Lodge 1, slouched in the chair, and was wearing a sling to the left side, the left arm was not in the sling, instead it was hanging straight down. Observed R7 grimacing while sitting in the chair.

An observation on 02/02/2026 at 12:05 PM, showed R7 grimacing and rubbing the left shoulder while sitting in the chair, sling was in same position and left arm still not in the

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sling.

An observation on 02/02/2026 at 12:09 PM showed Staff BB, Activities, brought R7 a meal tray and asked about the shoulder. R7's left arm was still outside the sling; the sling was hanging on the left side of the body above the elbow.

An observation on 02/02/2026 at 12:23 PM showed R7's left arm was still outside the sling; the sling was hanging on the left side of the body above the elbow.

An observation on 02/02/2026 at 2:48 PM showed R7 sitting upright on their bed with the left arm straight out with their hand flat on the bed. The sling was still up on the shoulder and left arm was not inside the sling.

On 02/02/2026 at 2:48 PM, R7 stated that they had fractured their shoulder when they fell and when asked if it hurt stated "OH YEA!"

Record review of R7's Temporary Service Plan (TSP), dated 02/03/2026, documented R7 was at an increased risk for falls with the limited use of their left arm. Staff would assist with R7's activities of daily living need as needed. The medication technicians would administer pain medication as ordered and monitor for its effectiveness and side effects. The TSP did not say that R7 needed full assistance with dressing, inability to use a walker and required the use of wheelchair.

An observation on 02/03/2026 at 12:46 PM showed R7 sitting upright on the side of the bed. R7's arm was straight out by the side of their body with the sling up on the shoulder. R7 was observed to be repositioning frequently and noted at times to rock back and forth on their bed. R7 grabbed their left arm and grimaced.

On 02/03/2026 at 12:46 PM, R7 stated their arm was "no better" and the pain was "bad enough."

An observation on 02/03/2026 at 1:44 PM showed R7, in Lodge 1, sitting in a chair, the left arm was hanging straight out next to their body with their hand resting on a seat cushion with the sling positioned up on their shoulder, the arm was not inside the sling.

An observation on 02/03/2026 at 2:11 PM showed R7 still sitting in the chair with their left arm hanging straight down and not in the sling.

On 02/03/2026 at 4:05 PM, R7 stated that they were not doing all that great as their left arm hurt.

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An observation on 02/03/2026 at 4:05 PM showed R7's sling was on their shoulder with the elbow not supported or positioned correctly in the sling. R7 was seen grimacing and holding the left shoulder. Staff G, Health Services Director, and Staff L, Medication Technician, observed assisted R7 to stand up from the chair, R7's arm continued to be out of the sling when Staff G and Staff L walked them to the front of the lodges multipurpose room where they assisted them to sit in another chair. Staff G, attempted to reposition R7's left arm in the sling but left to assist another resident.

On 02/03/2026 at 4:12 PM, R7 stated their left arm hurt and had sling for about a week. R7 was asked if they had seen a physician for the left arm, R7 stated "that would be nice."

An observation and interview on 02/04/2026 at 12:23 PM, showed R7 sitting upright on their bed, leaned back against the wall with their left arm hanging straight out and the sling up on their shoulder, the left arm was not in the sling. R7 stated that it had been a few days since they broke their shoulder and was still experiencing pain.

On 02/04/2026 at 1:55 PM, Staff H stated R7 required more assistance with care since they fractured their shoulder. Staff H stated R7 was having pain with their shoulder and was bruised.

On 02/05/2026 at 12:33 PM, Staff G stated R7's sling for their fractured shoulder was designed to hold the arm to the body and keep it from moving. Staff G stated the bent part of the sling was to hold the elbow with the strap around their neck and their entire arm in the sling with the elbow bent at a ninety-degree angle. Staff G stated they did not educate the medication technicians or the caregivers on the use and proper fitting of the sling after R7 returned to the facility with the sling from the hospital.

Record review of progress notes 01/31/2026 through 02/06/2026, documented there was no assessment of R7 after they had fallen, broke their shoulder bone and was now in pain and need to use a sling to immobilize their arm by Staff G or a qualified assessor.

On 02/10/2026 at 5:05 PM, Collateral Contact 5 (CC5), Power of Attorney, stated R7 was not to use their arm and was to use the sling to keep them from using the arm for six weeks. CC5 stated that R7 needs the staff to ensure they wore the sling on properly and when they picked R7 for their appointment the sling was wrong and had to show staff the proper way it was to be worn.

Resident 11 (R11)

Record review of R11's Washington Health and Service Evaluation Results and Service Plan, dated 12/30/2025, documented R2 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included[redacted]

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[redacted]. R11 required extensive assistance one to two times a week with their showers. R11 was documented to have normal skin with a small area to their buttocks and “invalid response” documented if R11 had an active wound. R2 prefers female caregiver and required RN delegated tasks. R11 required max assistance with personal activities of daily living care and services with no wounds or skin issues.

Record review of R11’s document titled, “Referral”, dated 11/21/2025, documented R11 was being referred to home health for wound management for stage two pressure sore to left buttocks.

Record review of the facility’s shower schedule, undated, documented R11 was scheduled to have showers every Tuesday and Friday on the evening shift.

Record review of the shower sheets documented R11 received five of nine scheduled showers for dates 12/01/2025 through 12/31/2025, and six of nine scheduled showers for dates 01/01/2026 through 01/31/2026.

Record review of R11’s document titled, “Office Visit Note,” dated 12/09/2025, documented R11’s primary care provider saw R11 for a follow up visit that included evaluation of skin issues. R11 was documented to have a stage two pressure sore with fresh skin on the buttocks due to sitting and would be referred to home health for management. The physician ordered zinc oxide forty percent for the stage one pressure sore and to encourage R11 to move around to help prevent further skin breaks.

Record review of R11’s RN delegation documents, dated 11/10/2025, documented they were delegated for oral medication, as needed, nasal, topical, inhalation and eye drop medication administrations. R11’s zinc oxide cream was a delegated task for the medication technicians to apply.

Record review of R11’s MARs, dated 12/01/2025 through 12/31/2026, documented R11 had an order that started on 11/05/2025 for zinc oxide forty percent to be applied to buttocks three times daily that was discontinued on 12/13/2025 at 2:00 PM and only had an as needed order that was administered on 12/25/2025.

Record review of R11’s MARs, dated 01/01/2026 through 01/31/2026, documented R11 only had the as needed zinc oxide forty percent order and was not administered one time.

Record review of R11’s MARs, dated 02/01/2026 through 02/05/2026, documented R11 started a new order on 02/03/2026 for zinc oxide forty percent three time daily with each diaper change for a rash. The as needed zinc oxide order was discontinued on 02/04/2026 that was for their buttock skin redness.

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Record review of R11's progress notes, dated 12/01/2025 through 02/05/2026, documented there were no weekly documented assessments of R11's buttocks stage two pressure wound completed by the LN.

On 02/04/2026 at 11:58 AM in Lodge 2 dining room, R11 was talking to Staff D and Staff J, Cook, that they did not get their shower yesterday and day before. At 12:00 PM, Staff M, Medication Technician, told R11 that they would make sure they got a shower today. R11 stated that they got told that all the time and it does not happen. R11 told Staff M that they paid for showers and really needed a shower. R11 stated they were to have two showers a week and prefer them in the afternoons. R11 stated that they have bedsores that hurt and why they needed their two showers a week. At 12:16 PM, Staff D stated that R11 was female care only and had refused their shower yesterday afternoon. Staff D stated either the medication technician or any of the female caregivers in Lodge 1 would assist R11 with their shower today.

On 02/04/2026 at 2:11 PM, Staff D stated R11 did not get their shower on day shift as they were female caregivers only.

On 02/04/2026 at 3:45 PM, Staff R, Caregiver, stated R11 was coherent and knows when they are to have their shower and last time they were provided care. Staff R stated R11 had a red rash in their groin area and sores on their buttocks. R11 got up from the side of their bed and was observed to scrunch up their face and moan when they stood up and stated that their buttock hurt. R11 entered the bathroom to use the bathroom. R11 wore a pull up with a sanitary napkin pad inside that were both dark yellow in color and saturated wet with a strong odor of urine. Both of R11's buttocks cheeks were deep red with some purplish areas. There were many small open skin areas to both buttocks cheeks with one small open area that was bleeding. R11 stated that their buttocks hurt and at times there is blood coming from those bed sores. At the medication room with Staff X, Caregiver, was the scheduled medication technician looked up the current treatment for R11's sores on their buttock on the MAR of the electronic record. Staff X stated it was zinc oxide forty percent to be applied three times daily with diaper change. Staff X put some of the cream in a medication cup and handed it to Staff R. Staff X stated they were not allowed to put the cream on R11 as they did not allow male caregivers or medication technicians to assist them.

On 02/05/2026 at 9:56 AM, Staff M stated the medication technicians were to apply cream to R11's buttock area as they had two open wounds.

On 02/05/2026 at 12:33 PM, Staff G stated they had not looked at R11's buttocks wounds as they do not allow male caregivers to look at their skin but was aware there was a few open skin areas. Staff G stated that R11's primary care physician oversights the wound on R11's buttocks and was unsure if Staff Z had looked at R11's buttocks. Staff G stated Staff Z would be the person to complete R11's weekly skin wound assessments and document.

On 02/05/2026 at 2:47 PM, Staff Z stated they reviewed all residents' weekly skin

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assessments to see if they required RN delegation and if they required RN delegation they would see those residents weekly. Staff Z stated they had not seen or were aware that R11 had a pressure wound on their buttocks. Staff G stated that R11's wound per the facility's electronic health records first started in October 2025 and then resolved. It recently restarted on 01/05/2026 with current treatment orders to apply zinc oxide cream for protection. Staff G stated to Staff Z that they were not allowed to look at R11's skin as they were male and R11 only allowed female caregivers or staff to provide care.

As of 02/05/2026 at 3:00 PM, R11's buttocks was last reviewed by a LN or healthcare provider was on 12/07/2025.

Resident 1 (R1)

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection," undated, showed R1 was the only resident who resided in R1's room.

On 02/02/2026 at 2:47 PM, observation of R1's room had R1's personal belongings on the left side of the room. There was a television mounted on the right side of the wall. Other than the television there were no additional personal belongings on the right side of the room that were observed.

On 02/04/2026 at 1:10 PM, Collateral Contact 3 (CC3), R1's Power of Attorney, stated R1's previous roommate had left their television mounted to the wall. CC3 expressed understanding that R1 was in a shared room and that in the future R1 would be assigned another roommate. CC3 stated the roommate had not yet been assigned and they did not think R1 would have a roommate for the foreseeable future. CC3 stated they lived out of state and took R1's television to a relative's house and when R1 received a new roommate they needed to make arrangements to bring R1 their television to use.

On 02/04/2026 at 3:21 PM, Staff C, Resident Care Coordinator, stated Resident 17 (R17) moved into R1's room.

On 02/05/2026 at 10:08 AM, observed R17 laid on the bed on the right side of the room and their personal belongings were on the nightstand.

On 02/05/2026 at 10:20 AM, Staff C stated R17 moved out of their room and into R1's room. Staff C stated Staff A was the person responsible who called and notified resident families when a room change occurred.

On 02/05/2026 at 1:20 PM, Staff A stated unless there was an emergency the

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administration would notify the residents power of attorneys before the resident received a new roommate. Staff A stated if there was a room transfer, they would contact resident power of attorneys before the resident was moved.

On 02/05/2026 at 3:15 PM, Staff C stated R17 moved into R1's room three days ago.

On 02/05/2026 at 2:08 PM, CC3 stated no one from the facility had called to inform them R1 received a new roommate. CC3 reiterated they lived out of state and needed to make arrangements to bring R1's television to the facility.

Resident 15 (R15)

On 02/03/2026 at 2:10 PM, R15 had been observed in the hallway, and their slipper was not properly on their foot as their heal was on top of the slipper. Staff H, Caregiver, was notified of R15's slipper not being properly on as it presented a fall risk. Staff H escorted R15 into a room, when R15 returned to the hallway they wore yellow hospital socks. R15's sock had a hole and their middle toenail stuck out through the hole. R15's hole in their sock was brought to Staff H's attention and they stated they would change R15's sock.

On 02/04/2026 at 12:24 PM, R15 was observed in the dining room with the yellow socks on that had a hole in the middle where their middle toe stuck out.

Resident 2 (R2)

On 02/02/2026 at 8:47 AM, upon opening the door into Lodge 2, R2 was observed standing at the door with no shirt with their sweatpants that were wet from inner thigh area around the leg and to the buttocks. R2 wandered around the Lodge independently. Staff Q, Caregiver, brought R2 into their room to get their clothes changed. When Staff Q was putting on R2's clothes in their room, the windows blinds were open and Resident 24 walked by observed R2 be dressed.

On 02/03/2026 at 1:21 PM, observed R2 was outside of Lodge 2's medication room and sat on an end table that was next to a chair. Staff M confirmed the resident was R2 and walked past R2 to enter the medication room.

Resident 25 (R25)

On 02/02/2026 at 2:26 PM, observed R25 was sitting in their wheelchair in the living area near the couches in the television area. R25 sat in their wheelchair on their left hip, slouched on their tailbone area with their left forearm and elbow resting on the seat cushion. R25 at times with lean their upper body forward and then back to the back of

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the wheelchair while holding on to both sides of the arm rests. R25's blue sweatpants and shirt had residual food crumbs, particles and dried shinny substance on them. Staff H, Caregiver, walked by R25 and said "Hi." Staff H never stopped to assist R25 with reposition in their wheelchair or offered to change their soiled clothes.

Grievances

RCW 70.129.060 "Grievances. A resident has the right to: (1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents."

Record review of the facility's policy, "Complaint and Grievance Resolution," dated 07/07/2024, documented residents had the right to express their complaints and dissatisfactions without fear of reprisal. Informal methods included discussions were encouraged between the resident, executive director, and the person with whom the concern involved. A resident could bring the problem to a staff member who would work with the resident to solve the problem, and the staff member would discuss the problem with the executive director. Formal methods included to put the concern in writing and place it in the communication box. The executive director would investigate all complaints and act on all substantiated problems within 72 hours.

On 02/04/2026 at 2:03 PM, Staff A stated when they received a grievance, they addressed it. Staff A and Staff T, Business Office, stated they had not had any documented grievances from 12/01/2025 through current that they needed to follow up on.

Resident 17 (R17)

Record review of the facility's, "Maintenance Request Form," dated "01/06", documented R17 requested a lock due to male residents entering their room when they used the bathroom. The maintenance slip was not marked off as urgent or not urgent. The for office use only section that showed who the task was assigned to, the date started, the date completed, the total time spent, the material cost, and remarks section were blank.

On 02/04/2026 at 3:04 PM, Staff C stated R17 moved rooms on 02/03/2026, before their room move R17 was in room [redacted]. Staff C stated they accidentally wrote the wrong room number on the 11/06/2025 work order and the room that needed a key was for room [redacted]. Staff C stated that R17 wanted a lock on their apartment door because a male resident kept entering their room. Staff C stated that R17 wanted a lock on their door, so the male resident did not enter their apartment room when they were in the bathroom.

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Observation on 02/04/2026 at 3:25 PM, observed R17's former apartment room number [redacted] outside door handle did not have a lock.

On 02/05/2026 at 10:12 AM, R17 stated when they were in their previous apartment room, they requested a key and a door that locked so that male residents could not enter their room without permission. R17 stated male residents entered their room and deliberately peed on their bathroom floor and laid down in their roommate's bed. R17 stated they did not feel safe and screamed telling the male resident to get out. R17 stated that they had a hard time sleeping at night because they did not know what was going to happen to them once they did.

On 02/05/2026 at 10:20 AM, Staff C stated they made a work order on R17's behalf for them to get a lock and key because a male resident kept entering R17's room and urinating on their floor.

Resident 5 (R5)

On 02/05/2026 at 9:35 AM, Collateral Contact 2 (CC2), R5's Resident Representative, stated that whenever they visited R5 they observed male residents enter R5's apartment without permission. CC2 stated they reported it to Staff A and Staff T when they visited R5 mid-January when they observed a male resident enter R5's apartment, they sat on the bed across from R5 and the male resident stared at R5. CC2 stated R5 started to cry and screamed at the male resident to leave. CC2 stated their spouse had to physically leave the room to find a facility staff member to get the male resident out of R5's apartment. CC2 expressed frustration that male residents entered R5's apartment in the middle of the night and early morning. CC2 stated R5 woke up terrified, cried, and stated they could not sleep. CC2 stated they did not think R5 felt safe living in the facility. CC2 stated that when they visited R5 they brought groceries and they felt like other residents flocked to R5's room to take what was brought in. CC2 stated they do not feel like they could continue to bring R5's personal belongings to the facility because other residents stole them. CC2 stated they brought R5's picture albums in and they were found in other residents' rooms. CC2 stated all R5's clothing were labeled with their name. CC2 stated R5's tennis shoes were missing and over 50 pairs of socks had gone missing. CC2 stated R5's laundry never got returned to them. CC2 stated when they visited R5 around Christmas and mid-January they felt like R5 appeared dirty and R5's hair was visibly greasy. CC2 stated supposedly R5 participated in the community activities. Staff A stated around Christmas they would send CC2 pictures and videos of R5 participating and they had yet to receive any.

Resident 3 (R3)

On 02/10/2026 at 4:00 PM, Collateral Contact 1 (CC1), R3's Power of Attorney stated R3's clothes went missing often and R3 was observed to wear clothes that were not theirs.

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Resident 19 (R19)

On 02/04/2026 at 3:41 PM, observed R19 was in their apartment when they opened their door and agreed to talk to the Department. R6 attempted to enter R19's room and started to walk through their doorway. R19 yelled at R6 to get out and physically started to shut the door on R6. R19 shut the door and had to keep their hand on the lever. R19 stated R6 needed to let go of their door before they had the ability to lock their door. R6 let go of R19's door and R19 locked their door. R19 stated they always had to keep their door locked or other residents entered and slept in their bed. R19 stated they could never find a caregiver when they needed one. R19 stated they gave the facility staff their laundry on 02/01/2026 and it was still not returned to them.

On 03/03/2026 at 4:10 PM, Staff A stated resident laundry should be delivered back to them within three days.

Resident 4 (R4)

On 02/03/2026 at 12:55 PM, R4 stated the staff pay attention to them and go to any of them to report concerns but the staff do not communicate with each other and the management. R4 stated they report their concerns to Staff C. R4 stated their concerns were never addressed or communicated to the staff that needed to know.

On 02/04/2026 at 10:02 AM, Collateral Contact 4 (CC4) Spouse of R4, stated they report concerns to staff and would be told they will address them, but then there is no follow up. CC4 stated they go to Staff A with all their concerns.

Resident 7 (R7)

Record review of R7's incident form, dated 01/30/2026, documented R7 was found on the floor in the middle of their room and were wearing pants that were to big for them that were around R7's ankles. R7 stated they tripped over the pants they were wearing. R7 stated it felt like they had dislocated their arm and were sent to the hospital. R7 returned to the facility with a left shoulder fracture.

On 02/04/2026 at 12:14 PM, R7 stated when he reports concerns to the staff they do not always pay attention and the concerns reported were not followed up or resolved.

On 02/10/2026 at 5:05 PM, Collateral Contact 5 (CC5) Power of Attorney for R7, stated they felt safe with R7 living at the facility as long as they were in their own clothes. CC5 stated they fell and broke their left shoulder because they were wearing clothes that were not theirs and too big. CC5 stated they ask about R7's clothes each time they visited without any follow up. CC5 stated they bought R7 new shoes, pants, jacket and several shirts for Christmas and all were gone after one week. CC5 stated it has been an

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on-going concern that they ask about with each visit. CC5 stated they mark each new clothing with R7's first and last name. CC5 stated they always report any concerns they have and there was never any follow up.

Confidentiality of Personal and Medical Records

RCW 70.129.050 "Privacy and confidentiality of personal and medical records. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Personal privacy includes accommodation, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility to provide a private room for each resident however, a resident cannot be prohibited by the facility from meeting with guests in his or her bedroom if no roommates object."

On 02/02/2026 at 9:31 AM, Staff A stated there was a sunroom in each lodge that residents sat in and looked out the window. Lodge 1's sunroom had five boxes stacked up against the wall. Staff A stated resident care supplies were regularly dropped off at the facility and Staff C was responsible to put the resident care items away in their rooms. At 12:19 PM one box had a shipping label with Resident 21 (R21), and the box had Resident 23's (R23) first and last name displayed. There were three boxes with Resident 22 (R22)'s first and last name displayed.

On 02/03/2026 at 12:44 PM, observed Lodge 1's sunroom had five boxes stacked up against the wall one box had a shipping label with R21, and the box had R23 first and last name displayed. There were three boxes with R22's first and last name displayed. At 1:30 PM, the five boxes were still present.

On 02/04/2026 at 12:26 PM, Lodge 1's sunroom had five boxes stacked up against the wall, five boxes of resident supplies that included three boxes for R22 and two boxes for Resident 2 (R2). R6 and R15 were observed in the sunroom.

On 02/05/2026 at 10:19 AM, observed in Lodge 1's sunroom there were five boxes of resident supplies that included three boxes for R22 and two boxes for R2.

On 02/05/2026 at 1:20 PM, Staff A acknowledged Lodge 1 sunroom had resident supplies with resident's first and last names on the boxes. Staff A stated Staff C and other facility staff did their best to distribute resident supplies promptly after they were delivered.

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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 5/18/2026 jmj 5/21/26

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

Jodi McStephens — 4/17/26 5/15/26
Administrator (or Representative) — Date
request extension, signed date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete on-going assessments focused on residents identified problems and changes of condition for 2 of 7 sampled residents (Resident 7 and 8). This failure placed Resident 7 and Resident 8 at risk for unidentified and unmet care needs, decline in condition, and a decreased quality of life.

Findings included...

Record review of the facility's policy, titled, "Change of Condition," dated 09/24/2024, documented any change in resident's condition that was observed or suspected by any staff member, must be reported to the medication technician on duty or call who would evaluate the resident, document the change in the medical record and notify the health services director (HSD) and registered nurse. The community nurse would review reports and assess the resident in a timely manner that included a full or problem focused assessment. The community nurse would document findings, residents' status and interventions made as a result of the assessment. All changes of conditions would be documented in the residents' health record with the HSD ensuring appropriate follow-up was taken.

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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-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete on-going assessments focused on residents identified problems and changes of condition for 2 of 7 sampled residents (Resident 7 and 8). This failure placed Resident 7 and Resident 8 at risk for unidentified and unmet care needs, decline in condition, and a decreased quality of life.

Findings included…

Record review of the facility's policy, titled, "Change of Condition," dated 09/24/2024, documented any change in resident's condition that was observed or suspected by any staff member, must be reported to the medication technician on duty or call who would evaluate the resident, document the change in the medical record and notify the health services director (HSD) and registered nurse. The community nurse would review reports and assess the resident in a timely manner that included a full or problem focused assessment. The community nurse would document findings, residents' status and interventions made as a result of the assessment. All changes of conditions would be documented in the residents' health record with the HSD ensuring appropriate follow-up was taken.

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R8

Record review of R8's Washington Health and Service Evaluation Results and Service Plan, the facilities version the negotiated service agreement and assessment combined, dated 08/06/2025, documented R8 moved into the facility on [redacted]/2025 and was being evaluated for change of condition. R8 had multiple areas of deep purple and red bruising, swelling and visible redness across the buttocks area. There were some sore areas that were open in the middle and a dime sized partially open black area to the lower right side of their buttocks. R8 required two-person assistance with mobility, ambulation and bathing for safety and stability and did not have any history of behaviors. Staff were to report promptly to the health services director (HSD) for further assessment if R8 experienced any behaviors or complaints of pain.

Record review of R8's progress note, dated [redacted]/2025 at 5:16 AM, documented staff found R8 on the floor lying on their right side complaining of hip pain and was transported to the emergency room. It was documented that R8's physician was faxed of R8's fall and transferred to the emergency department.

Record review of R8's progress note, dated [redacted]/2025 at 1:24 AM, documented the emergency room department's physician called the facility reporting that R8 would be returning to the facility with new orders for antibiotics, clean dressing and need for wound care as soon as possible.

Record review of R8's progress note, dated [redacted]/2025 at 3:34 AM, documented they returned to the facility from a pressure sore check that was near their buttocks.

Record review of R8's progress note, dated [redacted]/2025 at 5:09 AM, documented R8 had returned to the facility after being sent back to the emergency room for the sore on their buttocks. There was no documentation that R8's physician was notified.

Record review of R8's After Visit Summary (AVS), dated [redacted]/2025, documented they were seen for a wound check for their pressure sore. R8 received new orders to start antibiotics for any superimposed (an infection on top of skin already damaged) skin infection and negative pressure wound therapy (a device that helps skin wounds heal). The hospital had cleaned and provided dressing supplies for their wounds.

Record review of R8's progress note, dated 08/11/2025 at 5:46 AM, documented R8 had a fall that night.

Record review of R8's progress note, dated 08/11/2025 at 12:13 PM, documented R8's wound on their buttocks was bleeding heavily and was sent back to the emergency department for further evaluation and wound care management.

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Record review of R8's After Visit Summary, dated 08/11/2025, documented they were seen for a wound check for their chronic ulcer on their buttocks with new orders to stop their blood thinner.

Record review of R8's progress note, dated 08/13/2025 at 11:48 AM, Staff G, Health Services Director, documented that they had faxed R8's physician for an order for home health referral for wound care and catheter management. There was no other documentation or assessment of R8 after their falls or of their wound.

Record review of R8's progress note, dated 08/15/2025 at 6:44 AM, documented they were found sitting on the floor on a mat next to their bed. R8 reported they got too close to the side of the bed and slid out of bed.

Record review of R8's progress note, dated 08/15/2025 at 9:10 PM, documented R8 continued to be very active yelling, screaming, trying to get in and out of bed independently and wanting to go to the hospital.

Record review of R8's progress note, dated 08/21/2025 at 8:00 AM, Staff G documented the caregivers reported R8's wound had worsened. R8 had a pressure injury to the sacral (tailbone) and perineal (base of the buttocks and spine) area. R8's base of the wound was yellow slough (dead tissue that prevents wound healing) and necrotic (dead, non-viable tissue). The wound had foul smelling infected drainage with the surrounding skin red and inflamed that caused R8 to have discomfort. R8 was transported to the hospital emergency room.

Record review of R8's progress notes, dated [redacted]/2025 through 08/20/2025, documented that there were no progress notes or evaluations from Staff G of R8 after their numerous falls and buttocks wound that resulted in evaluation at the hospital emergency room with new physician orders and medication changes.

Record review of R8's progress notes, dated 08/21/2025 at 9:27 PM, documented R8 was doing well from returning to the facility.

Record review of R8's progress note, dated 08/22/2025 at 3:12 PM, showed Staff G documented that they tried to call R8's physician who was out of the office and would call back the following week. There was no other documentation about R8's condition and wound.

Record review of R8's progress note, dated 08/22/2025 at 9:30 PM, documented the medication technician documented R8's wound was pink and gray.

Record review of R8's progress note, dated 08/23/2025 at 12:37 PM, documented their bed sore wound appeared to be worsening with constant drainage.

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Record review of R8's progress note, dated 08/23/2025 at 12:53 PM, documented they were found on the floor in their room.

Record review of R8's progress note, dated 08/26/2025 at 10:40 AM, documented Staff G talked with R8's physician to send the home health referral for wound care and catheter management to the facility.

Record review of R8's progress note, dated 08/27/2025 at 11:21 AM, documented Staff G faxed the home health referral to the home health agency.

Record review of R8's progress note, dated 08/28/2025 at 9:56 PM, documented their bed sore wound continue to look bad.

Record review of R8's progress note, dated 08/30/2025 at 2:00 AM, documented they were transported to the hospital for the bed sore wound.

Record review of R8's provided medical records, dated 08/22/2025 through 08/29/2025, documented that there were no progress notes or evaluations from Staff G of R8 after their numerous falls and buttock wound that resulted in evaluation at the hospital emergency room with new physician orders and medication changes.

R7

Record review of R7's Washington Health and Service Evaluation Results and Service Plan, dated 01/25/2026, that was a quarterly assessment, documented R7 moved into the facility on [redacted]/2014 with multiple medical diagnoses that included [redacted] and [redacted]. R7 required minimal assistance with cues and prompts from staff to use their walker, transfers and mobility. R7 was alert, oriented, able to make needs known and no complaints of pain noted.

Record review of R7's progress note, dated 01/30/2026 at 9:04 PM, documented they returned to the facility from the hospital visit with shoulder pain that required pain medication be administered.

Record review of R7's After Visit Summary, dated 01/30/2026, documented they were seen at the emergency department after a fall. R7's imaging of their left shoulder, documented they had a humeral neck fracture (upper arm broke at the head part by the shoulder). R7 was to keep their arm immobilized in a sling and use ice for pain management.

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Record review of R7's progress note, dated 02/01/2026 at 5:12 AM, documented they refused to sleep in their room, complained of pain during their shift, and was provided medication that only reduced some of the pain.

Record review of R7's progress note, dated 02/01/2026 at 1:21 PM, documented they had a hard time lifting up both of their arms.

Record review of R7's progress note, dated 02/01/2026 at 9:36 PM, documented they were uncomfortable and complained of pain to their shoulder, after they had been medicated for the pain.

Record review of R7's medical records provided dated 01/31/2026 through 02/06/2026, documented there was no assessment of R7 after they had fallen, broke their shoulder bone and was now in pain that required the use of a sling to immobilized the arm.

On 03/05/2026 at 8:30 AM, Staff G stated all completed assessments were documented on the Washington Health and Service Evaluation Results and Service Plan.

This is a recurring deficiency previously cited on 05/14/2025 and 12/19/2024 under subsections (2)(a)(b)(i).

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 5/18/2026 .

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

Jodene Stephens — Administrator (or Representative)

4/17/26 — Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

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Record review of R7's progress note, dated 02/01/2026 at 5:12 AM, documented they refused to sleep in their room, complained of pain during their shift, and was provided medication that only reduced some of the pain.

Record review of R7's progress note, dated 02/01/2026 at 1:21 PM, documented they had a hard time lifting up both of their arms.

Record review of R7's progress note, dated 02/01/2026 at 9:36 PM, documented they were uncomfortable and complained of pain to their shoulder, after they had been medicated for the pain.

Record review of R7's medical records provided dated 01/31/2026 through 02/06/2026, documented there was no assessment of R7 after they had fallen, broke their shoulder bone and was now in pain that required the use of a sling to immobilized the arm.

On 03/05/2026 at 8:30 AM, Staff G stated all completed assessments were documented on the Washington Health and Service Evaluation Results and Service Plan.

This is a recurring deficiency previously cited on 05/14/2025 and 12/19/2024 under subsections (2)(a)(b)(i).

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-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

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(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the physician after there was a change in condition or recent hospitalization for 2 of 7 residents (Resident 8 and 6). This failure placed both residents at risk for medical complications due to the physician being unable to evaluate the significance of the resident change of condition and provide instructions.

Findings included…

Record review of the facility's policy, "Change of Condition," dated 09/24/2024, documented any change in a resident's condition that was observed or suspected by any staff member would be reported so the resident could be evaluated. If it was determined that the resident's condition was unstable and or beyond the score of services provided by the facility the resident would be transported to the hospital. The resident's family and primary care provider would be notified.

Record review of the facility's policy titled, "Accidents, Incidents and Unusual Occurrences," dated 02/15/2024, documented administration or other department heads were to notify the resident's primary care provider if an incident was significant, injury related or involved a resident.

Resident 8 (R8)

Record review of R8's Washington Health and Service Evaluation Results and Service Plan, dated 07/29/2025, documented they required moderate nursing services that included scheduling appointments and coordinating with their physician.

Record review of R8's progress note, dated 07/29/2025 at 6:23 PM, documented R8 was found lying on the floor in between their bed and nightstand. R8 reported they fell when they tried to transfer and got a rug burn on their right knee. There was no documentation the R8's physician was notified of the fall.

Record review of R8's progress note, dated 08/01/2025 at 7:55 PM, documented they self-reported they had fallen out of their chair three times during the evening and had to crawl to the door to get assistance from staff to get up. There was no documentation that R8's physician was notified.

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Record review of R8's progress note, dated 08/01/2025 at 8:23 PM, documented R8's roommate notified the facility staff that R8 was on the floor. R8 complained of their buttocks being sore after they had fallen out of their chair that was not locked and rolled away when they tried to transfer. There was no documentation that R8's physician was notified.

Record review of R8's progress note, dated 08/02/2025 at 5:26 AM, documented staff found R8 on the floor when they were completing their last rounds for the night. R8 reported they fell out of bed and endured small scratches and rug burn areas on both of their legs. There was no documentation that R8's physician was notified.

Record review of R8's progress note, dated 08/03/2025 at 1:20 AM, documented staff found R8 on the floor next to their bed and wheelchair after R8's roommate reported to the staff that R8 was on the floor. R8 reported they fell trying to get up to use the bathroom. There was no documentation that R8's physician was notified.

Record review of R8's progress note, dated 08/04/2025 at 2:12 PM, documented R8 attempted to stand up from their wheelchair and fell on their right side in the sunroom. There was no documentation that R8's physician was notified.

Record review of R8's progress note, dated [redacted]/2025 at 5:16 AM, documented staff found R8 on the floor lying on their right side complaining of hip pain and was transported to the emergency room. It was documented that R8's physician was faxed of R8's fall and transferred to the emergency department.

Record review of R8's progress note, dated [redacted]/2025 at 1:24 AM, documented the emergency room department's physician called the facility reporting that R8 would be returning to the facility with new orders for antibiotics, clean dressing and need for wound care as soon as possible. There was no documentation that R8's physician was notified of the wound, need for wound care and change in the resident's condition.

Record review of R8's progress note, dated [redacted]/2025 at 5:09 AM, documented R8 had returned to the facility after being sent back to the emergency room for the sore on their buttocks. There was no documentation that R8's physician was notified.

Record review of R8's After Visit Summary (AVS), dated [redacted]/2025, documented they were seen for a wound check for their decubitus ulcers. R8 received new orders to start antibiotics. The AVS documented the paperwork was to be shared with their physician of the changes to their medications and reason for the visit. There was no documentation that showed R8's physician was faxed this information provided.

Record review of R8's progress note, dated 08/11/2025 at 5:46 AM, documented R8 had

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a fall that night. There was no documentation that R8's physician was notified.

Record review of R8's progress note, dated 08/11/2025 at 12:13 PM, documented R8's wound on their buttocks was bleeding heavily and was sent back to the emergency department for further evaluation and wound care management. There was no documentation that R8's physician was notified. At 10:59 PM R8 returned to the facility.

Record review of R8's After Visit Summary, dated 08/11/2025, documented they were seen for a wound check on their chronic ulcer on their buttocks with new orders to stop their blood thinner.

Record review of R8's progress note, dated 08/15/2025 at 6:44 PM, documented R8 was found sitting on the mat next to their bed. R8 stated they got close to the edge and slid out of bed. There was no documentation that R8's physician was notified.

On 02/05/2026 at 8:16 AM, all R8's physician notifications made by the facility were requested since admission [redacted] 2026 through discharge [redacted]/2026. As of 02/06/2026 at 4:14 PM, the facility was unable to provide documentation that R8's physician was notified of all the incidents and changes R8 experienced.

On 02/12/2026 at 9:27 AM, the facility was requested to provide any proof that R8's physician was notified of the changes and falls R8 experienced during their stay at the facility.

Record review of an email sent to the Department on 02/12/2026 at 12:43 PM, documented the facility only had gotten one fax reply from R8's physician that was a home health referral dated 08/26/2025. The facility provided a screenshot of the sent electronic faxes, dated 07/29/2025 through 08/28/2025, documented R8's physician was faxed five times that included dates 07/30/2026, 08/06/2026, 08/13/2026, 08/22/2026 and 08/28/2026. There was no description or other documentation attached that showed what was faxed or nature of the notification.

Resident 6 (R6)

Record review of R6's, "WA Health and Service Evaluation Results and Service Plan," dated 01/23/2026, documented R6 moved into the facility on [redacted]/2024 and had a diagnosis of [redacted] R6 required extensive nursing services that included scheduling appointments and coordinating with their physician.

Record review of R6's, "Incident Form," dated 12/07/2025, documented R6 fell and struck their head against the wall that left a medium sized circular dent in the wall. R6

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verbalized head pain and dizziness. Emergency services responded and transported R6 to the hospital for further evaluation. It was documented that R6's medical provider had been notified on 12/07/2025.

Record review of R6's, "After Visit Summary," dated 12/07/2026, documented R6 was seen for their fall. Attached information included information on adult head injuries symptoms and general care.

Record review of R6's, "Incident Form," dated 12/15/2025, documented R6 had a fall and was found sitting in the courtyard on their bottom. It was documented that R6's medical provider had been notified on 12/16/2025.

Record review of R6's, "Incident Form," dated 12/18/2025, documented R6 was found sitting in the courtyard on their bottom. It was documented that R6's medical provider had been notified on 12/18/2025.

Record review of R6's, "Incident Form," dated 01/21/2026, documented R6 was shoved out of another resident's doorway. It was documented that R6's medical provider had been notified on 01/22/2026.

On 02/04/2026 at 12:32 PM, Staff G acknowledged R6 had multiple falls in December and in January and stated they were unsure if R6 experienced a change of condition because R6 appeared the same and just experienced falls.

On 02/04/2026 at 11:05 AM and on 02/05/2026 at 10:30 AM, R6's medical doctor notifications were requested to review for incident dates of 12/07/2025, 12/15/2025, 12/18/2025 and 01/21/2026.

As of 02/13/2026 at 10:01 AM there had been no documentation provided that showed proof that R6's medical doctor had been notified of incident dates of 12/07/2025, 12/15/2025, 12/18/2025 and 01/21/2026.

On 02/23/2026 at 12:55 PM, Staff Z, Clinical Director Registered Nurse Delegator, stated the medication technician on shift or a higher management would be responsible to notify the residents physician anytime they had a fall, emergency room hospital visit or change of condition.

This is a recurring deficiency previously cited on 04/27/2023 under subsections (1)(a)(3)(a)(b).

This document was prepared by Residential Care Services for the Locator website.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 5/18/2026 .

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

Jodi M. Stephens — Administrator (or Representative)

4/17/24 — Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor and evaluate the residents after a fall, after a resident refused a prescribed medication and after a change in residents' condition for 4 of 7 sampled residents (Resident 8, 6, 5 and 3). This failure contributed to R8 experiencing pain, decreased quality of life that resulted in multiple hospitalizations and need for high level of care and placed all residents at risk for unmet and unidentified care needs.

Findings included...

Record review of the facility's policy titled "Change of Condition," dated 09/24/2024, documented that any observed changes in the resident must be reported to the medication technician, documented in the resident's medical record, and the health services director notified. All changes of condition are to be documented in the resident's record, and the resident would be monitored via alert charting. Changes that should be reported to the nurse or other management included changes in behavior such as

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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

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor and evaluate the residents after a fall, after a resident refused a prescribed medication and after a change in residents' condition for 4 of 7 sampled residents (Resident 8, 6, 5 and 3). This failure contributed to R8 experiencing pain, decreased quality of life that resulted in multiple hospitalizations and need for high level of care and placed all residents at risk for unmet and unidentified care needs.

Findings included…

Record review of the facility's policy titled "Change of Condition," dated 09/24/2024, documented that any observed changes in the resident must be reported to the medication technician, documented in the resident's medical record, and the health services director notified. All changes of condition are to be documented in the resident's record, and the resident would be monitored via alert charting. Changes that should be reported to the nurse or other management included changes in behavior such as

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agitation and aggression and new or increased symptoms of pain.

Record review of the facility's policy titled, "Alert Charting," dated 02/15/2024, documented alert charting would be implemented when a resident's condition required increased monitoring and observation for a limited period. The licensed nurse or shift supervisor was responsible to initiate alert charting and maintain it for at least 72 hours. The health services director was responsible to ensure the documentation occurred. Unless otherwise directed by the licensed nurse or health services director conditions that required alert charting but were not limited to included when a fall occurred and behavioral changes.

Resident 8 (R8)

Record review of R8's Washington Health and Service Evaluation Results and Service Plan (facility's version of the assessment and service plan in one document), dated [redacted]/2025, documented R8 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted] R8 had three small wounds on their buttocks area and redness. There was no documentation that the wounds were open, the color or further description. R8 did not have any chronic, current and or potential skin conditions. R8 received nurse delegated services without anything specific being listed.

Record review of R8's Washington Health and Service Evaluation Results and Service Plan, dated 08/06/2025, documented R8 moved into the facility on [redacted]/2025 and was being evaluated for change of condition. R8 had multiple areas of deep purple and red bruising, swelling and visible redness across the buttocks area. There were some sore areas that were open in the middle and a dime sized partially open black area to the lower right side of their buttocks. R8 required two-person assistance with mobility, ambulation and bathing for safety and stability and did not have any history of behaviors. Staff were to report promptly to the health services director (HSD) for further assessment if R8 experienced any behaviors or complaints of pain.

Record review of R8's Medication Administration Record (MAR), dated 07/01/2025 through 08/31/2025, documented there were no current orders for creams, dressings or any treatments for skin wounds.

Record review of R8's progress note, dated [redacted]/2025 at 3:22 PM, the LN documented R8's admission to the facility from a hospital stay. There was no documentation about the three small wounds and redness on R8's buttocks.

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Record review of R8's progress note, dated 07/30/2025 at 4:08 PM, documented Staff G, Health Services Director, had faxed R8's primary care physician for a home health referral for catheter management.

Record review of R8's progress note, dated 08/01/2025 at 8:23 PM, documented R8's roommate found them sitting on the floor and alerted staff. R8 had slide out of their chair when they tried to transfer themselves to the bathroom. R8 complained of their buttocks being sore.

Record review of R8's progress note, dated 08/02/2025 at 5:26 AM, documented they were found on the floor. R8 was found to have small scratches and rug burns "here and there on both legs."

Record review of R8's progress note, dated 08/06/2025 at 5:09 AM, medication technician documented R8's bruising looked the same as the previous night.

Record review of R8's progress note, dated 08/06/2025 at 12:17 PM, documented they had multiple areas of deep purple and red bruising across both buttocks. There was visible redness, swelling and the worst area was the start of an open sore in the middle. One skin area to the lower right side was the size of a dime, black and partially open with no obvious drainage. R8's physician was notified of their skins condition for treatment, guidance on wound care and next steps for managing the affected areas.

Record review of R8's progress note, dated 08/06/2025 at 12:48 PM and 9:33 PM, documented the medication technician applied barrier cream to the bruising on R8's buttocks.

Record review of R8's progress note, dated 08/07/2025 at 10:14 PM, documented they continued to have bruising on their buttock with open wounds and lots of redness.

Record review of R8's progress note, dated [redacted]/2025 at 5:16 AM, documented staff found R8 on the floor lying on their right side complaining of hip pain and was transported to the emergency room. It was documented that R8's physician was faxed of R8's fall and transferred to the emergency department.

Record review of R8's progress note, dated [redacted]/2025 at 9:45 PM, documented their buttocks continued to be bruised with slight redness.

Record review of R8's progress note, dated [redacted]/2025 at 1:24 AM, documented Staff C, Resident Care Coordinator, received a call from the hospital emergency rooms physician reporting that R8 would be returning to the facility with new orders for antibiotics, clean dressing and need for wound care as soon as possible.

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Record review of R8's progress note, dated [redacted]/2025 at 3:34 AM, documented they returned to the facility from a bed sore (skin injury caused by prolonged periods of pressure) check that was near their buttocks.

Record review of R8's progress note, dated [redacted]/2025 at 2:10 PM, the medication technician documented the dressing on R8's buttock was clean, dry and intact. The staff were to continue to monitored the bruising closely for any changes and report to the HSD or medication technician on shift.

Record review of R8's progress note, dated 08/10/2025 at 5:02 PM, documented R8's buttocks continued with bruising with redness and irritation. At 5:09 AM the medication technician documented R8's sore looked like it was not getting better.

Record review of R8's progress note, dated 08/10/2025 at 5:09 AM, documented R8 had returned to the facility after being sent back to the emergency room for the sore on their buttocks.

Record review of R8's After Visit Summary (AVS), dated 08/10/2025, documented they were seen for a wound check for their bed sore. R8 received new orders to start antibiotics for any superimposed ((an infection on top of skin already damaged) skin infection and negative pressure wound (another name for bed sore) therapy (a device that helps skin wounds heal). The hospital had cleaned and provided dressing supplies for R8's wounds.

Record review of R8's progress note, dated 08/10/2025 at 1:55 PM, documented R8's wound dressing was clean and intact.

Record review of R8's progress note, dated 08/10/2025 at 8:49 PM, documented R8's bruised wound was bleeding and not getting better. The medication technician covered the wound. At 8:55 PM, the medication technician documented that R8's wound dressing was changed.

Record review of R8's progress note, dated 08/10/2025 at 9:03 PM, documented R8 had a large bowel movement that required the dressing on their buttocks to be replaced.

Record review of R8's progress note, dated 08/11/2025 at 5:46 AM, documented R8 had a fall that night.

Record review of R8's progress note, dated 08/11/2025 at 12:13 PM, Staff G documented R8's wound on their buttocks was bleeding heavily and was sent back to the emergency department for further evaluation and wound care management.

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Record review of R8's progress note, dated 08/11/2025 at 3:07 PM, Staff G documented they spoke with the hospitals emergency room physician that R8 would not require the negative pressure wound therapy. R8's wound bleeding was from their blood thinning medication. Staff G informed the physician that they had contacted the outside home health agency that would evaluate R8 later that week for wound care treatment. At 10:59 PM the medication technician documented R8 retuned to the facility with their wound still bleeding.

Record review of R8's After Visit Summary, dated 08/11/2025, documented they were seen for a wound check for their chronic ulcer on their buttocks with new orders to stop their blood thinner.

Record review of R8's progress note, dated 08/12/2025 at 1:41 PM and 7:31 PM, the medication technician documented a dressing and barrier cream was applied to R8's buttocks wounds that were open and bruised.

Record review of R8's progress note, dated 08/13/2025 at 11:48 AM, documented that they had faxed R8's physician for an order for home health referral for wound care and catheter management. There was no other documentation or assessment of R8 after their falls or of their wound.

Record review of R8's progress note, dated 08/15/2025 at 6:44 AM, documented they were found sitting on the floor on a mat next to their bed. R8 reported they got too close to the side of the bed and slid out of bed.

Record review of R8's progress note, dated 08/15/2025 at 9:10 PM, documented R8 continued to be very active yelling, screaming, trying to get in and out of bed independently and wanting to go to the hospital.

Record review of R8's progress note, dated 08/21/2025 at 8:00 AM, Staff G documented caregivers reported R8's wound had worsened. R8 had a bed sore the tailbone and base of the buttocks and spine area. R8's base of the wound was yellow slough (dead tissue that prevents wound healing) and necrotic (dead, non-viable tissue). The wound had foul smelling infected drainage with the surrounding skin red and inflamed that caused R8 to have discomfort. The skin around the wound was moist and fragile. R8 was transported to the hospital emergency room.

Record review of R8's provided medical records, dated [redacted]/2025 through 08/20/2025, documented that there were no evaluations after numerous falls and buttocks wound that resulted in evaluation at the hospital emergency room with new physician orders and medication changes.

Record review of R8's progress notes, dated 08/21/2025 at 9:27 PM, documented R8

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was doing well from returning to the facility.

Record review of R8's progress note, dated 08/22/2025 at 10:38 AM, Staff C documented they faxed R8's primary care physician the hospitals after visit summary of their wound and request for home health referral.

Record review of R8's progress note, dated 08/22/2025 at 3:12 PM, documented Staff G documented that they tried to call R8's physician who was out of the office and would call back the following week. There was no other documentation about R8's condition and wound.

Record review of R8's progress note, dated 08/22/2025 at 9:30 PM, documented the medication technician documented R8's wound was pink and gray, cleaned and applied a new bandage.

Record review of R8's progress note, dated 08/23/2025 at 12:37 PM, documented their bed sore wound appeared to be worsening with constant drainage.

Record review of R8's progress note, dated 08/23/2025 at 12:53 PM, documented they were found on the floor in their room.

Record review of R8's progress note, dated 08/24/2025 at 5:17 AM, medication technician documented they changed the bandage to R8's bed sore that looked the same.

Record review of R8's progress note, dated 08/24/2025 at 3:25 PM, the medication technician documented the bed sore was cleaned, dried and dressed.

Record review of R8's progress note, dated 08/26/2025 at 10:40 AM, documented Staff G talked with R8's physician to send the home health referral for wound care and catheter management to the facility. There was nothing else documented to show the physician was notified the extent of R8's wound.

Record review of R8's progress note, dated 08/27/2025 at 11:21 AM, documented Staff G faxed the home health referral to the home health agency.

Record review of R8's progress note, dated 08/28/2025 at 9:56 PM, documented their bed sore wound continue to look bad.

Record review of R8's progress note, dated 08/28/2025 at 9:19 PM, documented they were transported to the hospital for the bed sore wound.

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Record review of R8's provided medical records, dated 07/29/2025 through 08/28/2025, documented there were only two notes describing R8's buttocks wound.

Record review of R8's provided medical records, dated 08/22/2025 through 08/29/2025, documented that there were no routine evaluations of R8 after numerous falls and buttocks wound that resulted in multiple evaluations at the hospital emergency room with new physician orders and medication changes.

On [redacted]/2026 at 1:55 PM, Staff H, Caregiver, stated R8 was moved out of the facility cause their wound was so bad. Staff G stated the medication technicians would cleanse R8's buttocks wounds with wound cleaner and then apply a skin tone colored sticky bandage. Staff G stated R8 would have continuous loose bowel movement that soiled and caused the dressing to come off. The medication technicians would have to clean and replace the bandage multiple times a day. Staff G stated that R8 fell a lot and every time they did their buttocks would bruise more after each fall. Staff G stated they were told that the facility does not do wound care and the medication technicians were the only one to put a dressing on R8's buttocks wound other than the hospital. Staff G stated R8's wound was good in size with flesh pink and black observed. Staff G stated it was often that R8's bowel movement would get in the wound and there was a foul smell from the wound. Staff G and other caregivers reported the concerns of R8's wound getting so bad to the licensed nurse.

On 02/05/2026 at 9:56 AM, Staff M, Caregiver, stated R8 came in with two to three small wound areas that were starting to open on their buttocks when they admitted to the facility. Staff M stated the wounds continued to get worse and worse with them bleeding a lot and R8 falling all the time. Staff G stated the medication technicians and caregivers would cleanse the wound with wound wash to the open areas with A and D ointment and a patch that was sticky skin tone. Staff M stated the skin tone patch would soak up so much pus drainage and would be really wet. Staff M stated there was a "dingy" reeked foul smell from the wound and R8 would be required to be changed frequently as he constantly had diarrhea bowel movements that would get inside the wounds. Staff M stated there were two open areas that were size of quarters with one being one inch in depth. Staff M stated that R8 experienced pain by making noises flinch their body when the wounds were cleansed or they were changed.

On 02/05/2026 at 12:33 PM, Staff G stated for all the skin conditions they were aware of, they would look and document on them weekly in the electronic record on a skin check sheet. Staff G stated the facility has a treatment administration record in their electronic system that was not used, and all treatments or delegated dressings would be on the medication administration record for the delegated staff to sign off on and completed. Staff G stated they would provide all R8's skin check sheets to the Department for review. As of 02/23/2026 no skin check sheets from the facility's electronic records were provided to review the weekly documentation of their wound during the facility stay.

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Resident 6 (R6)

Record review of facility resident records titled “WA Health and Service Evaluation Results and Service Plan,” dated 01/23/2026, documented R6 moved into the facility on [redacted] 2024 and had a diagnosis of [redacted]. R6 was independent with mobility and did not use an assisted device. R6 had three or more falls within the last 90 days.

Record review of facility resident records titled “Incident Form,” dated 12/07/2025, documented R6 fell and struck their head against the wall that left a medium sized circular dent in the wall. R6 verbalized head pain and dizziness. R6 was placed on neurological alert charting due to head impact, reported dizziness and pain. Emergency services responded and transported R6 to the hospital for further evaluation.

Record review of facility resident records titled “After Visit Summary,” dated 12/07/2025, documented R6 was seen for their fall. Adult head injuries symptoms to look for within the next hours to days included headache, nausea or vomiting, dizziness, sensitivity to light or noise, unusual sleep or grogginess, trouble falling asleep, personality changes, vision changes, memory loss, confusion, trouble walking or clumsiness, loss of consciousness (a temporary or prolonged state or unresponsiveness), inability to be awakened, stiff neck, weakness or numbness in any body part, and seizures (a sudden and uncontrolled surge of electrical activity in the brain that disrupts normal function).

Record review of R6’s provided medical records, showed that there was not any follow up monitoring documented from R6’s fall with injury on 12/07/2025.

On 02/04/2026 at 12:32 PM, Staff G, Health Services Director, stated that the indented hole next to R6’s apartment door near the ground was from R6’s fall on 12/07/2025.

Resident 5 (R5)

Record review of facility resident records titled “WA Health and Service Evaluation Results and Service Plan,” dated 11/03/2025, documented R5 moved into the facility on [redacted]/2024 and had a diagnosis of [redacted]. The facility staff assisted with R5’s self-administration of their prescribed medications. R5’s service plan did not indicate they refused their medication or had a history of refusing their medication.

Record review of facility electronic medication administration record (eMAR), dated 12/01/2025 through 12/31/2025, documented R5 had an order for divalproex sprinkle (a mood stabilizing medication) two times a day with meals that R5 refused on 12/07/2025 and 12/27/2025. An order for olanzapine (a mood stabilizing medication) two times a

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day that R5 refused on 12/07/2025 and 12/27/2025. An order for trazodone (a mood stabilizing medication) that R5 refused on 12/07/2025. An order for an antibiotic used to treat and prevent urinary tract infections that R5 refused on 12/27/2025.

Record review of eMAR, dated 01/01/2026 through 01/31/2026, documented R5 had an order for divalproex sprinkle and R5 refused 11 of 62 dosages. An order for olanzapine that R5 refused 12 of 62 dosages. An order for trazodone that R5 refused seven of 31 dosages.

Record review of facility resident records titled “Progress Notes,” dated 12/07/2025, documented that R5 refused to take their evening medications. There was no other documentation related to negative outcomes that R5 experienced due to medication refusal.

Record review of facility resident records titled “Progress Notes,” dated 12/27/2025, documented R5 refused medication and no further documentation related to negative outcomes that R5 experienced due to medication refusal.

Record review of facility resident records titled “Progress Notes,” for January 2026, showed no documentation that R5 refused medications or was monitored after refusals.

On 02/04/2026 at 4:49 PM, Staff K, Medication Technician, stated if a resident refused their medication after three days they placed the resident on alert charting.

On 02/04/2026 at 4:52 PM, Staff C stated if a resident refused their medication and missed three dosages of their medication or more, they placed the resident on alert charting, and notified Staff G.

On 02/04/2026 at 12:32 PM, Staff G stated if a resident missed one dosage of their medication, then they should be placed on alert charting for a minimum of three days. Staff G stated R5 picked and chose which medications they took. Staff G stated R5 refused their medications often and a temporary service plan (TSP) should have been created.

Record review of R5’s provided medical records, documented there was no documentation regarding R5’s medication refusals.

Resident 3 (R3)

Record review of facility resident records titled “WA Health and Service Evaluation Results and Service Plan,” dated 12/11/2025, documented R3 moved into the facility on [redacted]/2025 and had multiple medical diagnosis which included [redacted]

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[redacted]. R3 had frequent anxiety issues. R3 did not wander (travel aimlessly without a fixed destination or purpose) or exit seek (purposely attempting to leave).

Record review of facility resident records titled "Progress Notes," dated 01/28/2026, showed that R3, as documented by Staff C, had increased anxiety, aggression at times, and did not want to return to their room. R3 was exit seeking and looked for their spouse. An as needed medication was given but not effective. R3 was found in another resident's room sleeping with them. There were no further progress notes to review related to R3's mood and behaviors.

Record review of R3's provided medical records, documented there was no documentation or evaluation regarding R3's increased anxiety and aggression.

This is a recurring deficiency previously cited on 11/18/2024 and 04/27/2023 for subsections (1) (2)(a) (3)(a)(b).

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 5/18/2026.

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

Jodi M. Stephens — Administrator (or Representative)

4/17/26 — Date

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

(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 the resident Washington Health and Service Evaluation Results and Service Plan (facility's version of the Negotiated Service Agreement (NSA)) within 30 days following admission to the facility for 2 of 4 newly admitted residents (Resident 1 and 2). This failure placed both residents and other new residents at risk of unmet care needs and decreased quality of life.

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[redacted]. R3 had frequent anxiety issues. R3 did not wander (travel aimlessly without a fixed destination or purpose) or exit seek (purposely attempting to leave).

Record review of facility resident records titled “Progress Notes,” dated 01/28/2026, showed that R3, as documented by Staff C, had increased anxiety, aggression at times, and did not want to return to their room. R3 was exit seeking and looked for their spouse. An as needed medication was given but not effective. R3 was found in another resident’s room sleeping with them. There were no further progress notes to review related to R3’s mood and behaviors.

Record review of R3’s provided medical records, documented there was no documentation or evaluation regarding R3’s increased anxiety and aggression.

This is a recurring deficiency previously cited on 11/18/2024 and 04/27/2023 for subsections (1) (2)(a) (3)(a)(b).

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

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

(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 the resident Washington Health and Service Evaluation Results and Service Plan (facility’s version of the Negotiated Service Agreement (NSA)) within 30 days following admission to the facility for 2 of 4 newly admitted residents (Resident 1 and 2). This failure placed both residents and other new residents at risk of unmet care needs and decreased quality of life.

This document was prepared by Residential Care Services for the Locator website.

Findings included…

Record review of the facility's policy titled "Negotiated Service Agreement," dated 02/15/2024, documented the facility staff in coordination with the resident and or the resident representative and other interested parties would develop and implement an NSA for each resident to support their current assessed needs, capabilities, and preferences in accordance with Washington Administrative Code 388 78A 2130.

Resident 1 (R1)

Record review of R1's Face Sheet, undated, documented R1 admitted to the facility on [redacted]/2025.

Record review of R1's document titled, "Washington Health and Service Evaluation Results and Service Plan," dated 11/14/2025, documented it was R1's preadmission assessment.

Record review of R1's document titled, "Washington Health and Service Evaluation Results and Service Plan," dated 02/02/2026, documented it was R1's move in evaluation. Record review of all R1's provided NSA's, documented there was no NSA completed within 30 days of their admission to the facility on [redacted]/2025.

Resident 2 (R2)

Record review of R2's Face Sheet, undated, documented R2 admitted to the facility on [redacted]/2025.

Record review of R2's document titled, "Washington Health and Service Evaluation Results and Service Plan," dated [redacted]/2025, documented it was R2's move in evaluation.

Record review of R2's document titled, "Washington Health and Service Evaluation Results and Service Plan," dated 10/30/2025, documented it was R2's quarterly evaluation.

Record review of a facility email, sent to the Department on 02/03/2026 at 1:59 PM, documented there were no other service plans provided that were completed within 30 days of R2 admission of [redacted]/2025.

On 02/05/2026 at 12:33 PM, Staff G, Health Services Director, stated that the resident's

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assessments and service plans were the same document and would complete a service plan 30-days after admission.

On 02/05/2026 at 1:24 PM, Staff A, Executive Director, stated that all new residents admitted to the facility would have an assessment that was also their service plan completed 30-days after admitting to the facility.

This is a recurring deficiency previously cited on 07/23/2025 and on 05/21/2025 for subsection (2).

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 5/18/2026 .

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

Jodi M. Stephens — Administrator (or Representative)

4/17/26 — 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

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assessments and service plans were the same document and would complete a service plan 30-days after admission.

On 02/05/2026 at 1:24 PM, Staff A, Executive Director, stated that all new residents admitted to the facility would have an assessment that was also their service plan completed 30-days after admitting to the facility.

This is a recurring deficiency previously cited on 07/23/2025 and on 05/21/2025 for subsection (2).

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

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(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;

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(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 a 14-day assessment for 1 of 4 sampled residents (Resident 1 [R1]). This failure placed R1 at risk for having unmet care needs.

Findings included…

Record review of the facility's policy titled "Negotiated Service Agreement (NSA)," dated 02/15/2024, documented a qualified assessor completed a full assessment for each resident admitted into the community. The facility policy did not indicate when the timeline of when the full assessment was to be completed.

R1

Record review of R1's Face Sheet, undated, documented the facility admitted R1 on [redacted]/2025.

Record review of R1's document titled, "Washington Health and Service Evaluation Results and Service Plan," dated 11/14/2025, documented it was R1's pre-move in evaluation.

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Record review of R1's document titled, "Washington Health and Service Evaluation Results and Service Plan," dated 02/02/2026, documented it was R1's move in evaluation.

Record review of an email sent by the facility to the Department on 02/05/2026 at 2:44 PM, documented there were no assessments provided that were completed within 14 days of R1's admission on [redacted]/2025.

Record review of all R1's provided assessments, documented there was no assessment completed within 14 days.

On 02/05/2026 at 12.33 PM, Staff G, Health Services Director, stated the resident's assessments and service plans were the same document and they completed a 14-day assessment after admission.

On 02/05/2026 at 1:24 PM, Staff A, Executive Director, stated all new residents admitted to the facility would have an assessment that was also their service plan completed within 14-days of admission.

This is a recurring deficiency previously cited on 07/23/2025 and 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) 5/18/26 .

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

Jodi M. Stephens — Administrator (or Representative)

4/17/26 — 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) Maintain and provide staff persons with the necessary training, supplies, equipment, and personal protective equipment for preventing and controlling the spread of

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Record review of R1's document titled, "Washington Health and Service Evaluation Results and Service Plan," dated 02/02/2026, documented it was R1's move in evaluation.

Record review of an email sent by the facility to the Department on 02/05/2026 at 2:44 PM, documented there were no assessments provided that were completed within 14 days of R1's admission on [redacted]/2025.

Record review of all R1's provided assessments, documented there was no assessment completed within 14 days.

On 02/05/2026 at 12:33 PM, Staff G, Health Services Director, stated the resident's assessments and service plans were the same document and they completed a 14-day assessment after admission.

On 02/05/2026 at 1:24 PM, Staff A, Executive Director, stated all new residents admitted to the facility would have an assessment that was also their service plan completed within 14-days of admission.

This is a recurring deficiency previously cited on 07/23/2025 and 05/21/2025 .

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2610 Infection control.

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(2) The assisted living facility must:

(c) Maintain and provide staff persons with the necessary training, supplies, equipment, and personal protective equipment for preventing and controlling the spread of

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infections by:

(ii) Ordering supplies when necessary.

(d) Provide all resident care and services according to current acceptable standards for infection control;

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure staff performed hand hygiene during resident care for 5 of 5 staff observed (Staff D, H, Q, I and F), failed to provide necessary handwashing supplies in 4 of 4 resident care areas observed (Lodge 1 soiled laundry room, Lodge 2 soiled laundry room, Lodge 1 dining room and Resident 13's bathroom), failed to ensure staff implemented appropriate infection control practices to keep clean and soiled laundry separated for 1 of 2 Lodges (Lodge 2). These failures placed all residents, staff and visitors at risk for infectious disease or illness.

Findings included…

Record review of the facility's policy titled "Supplemental Infection Prevention and Control Program," dated 02/15/2024, documented the program was overseen by the executive director and the health services director. Actions to support infection prevention goals included follow the Centers for Disease Control (CDC) and Department of Health (DOH) guidelines for hand hygiene. Resident care and services were conducted according to current acceptable standards for infection control. Housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control.

Hand Hygiene and Laundry Room

Washington Administrative Code 388-78A-3040 Laundry. "(1) The assisted living facility must provide laundry and linen services on the premises, or by commercial laundry. (2) The assisted living facility must handle, clean, and store linen according to acceptable methods of infection control. The assisted living facility must: (a) Provide separate areas for handling clean laundry and soiled laundry; (b) Ensure clean laundry is not processed in, and does not pass through, areas where soiled laundry is handled."

Record review of the facility's policy infection control standard precautions, 02/15/2024, documented employees were to assume that all bodily fluids except sweat may contain transmissible infectious agents and required them to use standard precautions.

On 02/02/2026 at 8:51 AM, in Lodge 2, Staff Q, Caregiver, was observed holding

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Resident 2's (R2) arm taking them into the bathroom to get changed. Staff Q put on disposable gloves and had not used hand sanitizer or washed their hands with soap and water after touching R2's arm. At 8:54 AM, R2 was assisted to sit on the toilet and Staff Q removed R2's soiled pants and slippers. Staff Q put on a new pull up on R2's legs then grabbed a urinal (a device that holds urine or fluids to drain) from the back of the toilet. Staff Q grabbed the clamp to R2's catheter bag that was on their leg, opened the clamp and drained the urine into the urinal. While draining the catheter bag, Staff Q patted R2's bare leg with their gloved hand, then closed the clamp, set the urinal of urine on the ground by the toilet without a barrier and then wiped the tip of the catheter clamped tube with toilet paper and discarded in the trash. Staff Q removed R2's soiled pulled up. With the same gloved hands at 8:56 AM, Staff Q put on R2's clean pants, clean socks and their slippers. Staff Q patted R2 on the shoulder with their same gloved hands and grabbed R2's wrists and assisted them with standing up from the toilet. Staff Q removed the soiled pull up and threw it in the trash. Staff Q wiped R2's genitals with the same wet wipe used to clean their buttocks. With their same gloved hands, Staff Q pulled up R2's clean pull up, clean pants and pulled down their shirt over the top of their pants. At 8:59 AM, Staff Q dumped the urine from the urinal in the toilet, turned on the sink and rinsed the urinal out, turned off the water with their same gloved hand, and then disposed gloves. At 9:00 AM, Staff Q removed their disposable gloves and grabbed R2's arm with their bare hands to help them out of the bathroom to their bed. Staff Q removed their slippers and assisted R2 with lying down in bed and getting covered up with their blankets. At 9:03 AM, Staff Q turned R2's bedroom light off, pulled their keys out of their pocket, opened the door and exited R2's room. Staff Q was not observed during the entire observation to have washed their hands with soap and water or use of hand sanitizer. At 9:04 AM, Staff Q unlocked the door with their keys to the clean area of the laundry room passing multiple clean clothes with their soiled hands and the two soiled bags of clothes and trash to the soiled area of the laundry room. At 9:05 AM, Staff Q washed their hands in the soiled area of the laundry room with the only sink available. When Staff Q dried their hands, they used the clean paper towels that were sitting on top of a white pillow that had smeared brown substance on it.

On 02/02/2026 at 9:36 AM, Staff A, Executive Director, stated when staff had soiled laundry or trash, they were to enter the soiled laundry room door to discard.

On 02/02/2026 at 2:33 PM, observation of Resident 20 (R20) in their apartment and they stated they needed to use the bathroom. Staff H, Caregiver, was observed in the bathroom with R20 and they had blue disposable gloves on each of their hands. Without performing hand hygiene, Staff H exited the bathroom and retrieved their personal energy drink from the counter and drank it. Without performing hand hygiene Staff H and R20 were observed leaving R20's room to go into the common living room.

On 02/03/2026 at 1:35 PM, observed Staff D, Caregiver, was observed in Lodge 1 common area when Staff H, Caregiver, called out and asked if they were available to help them inside Resident 15 (R15)'s room. Staff D had been observed to exit the room with blue disposable gloves. At 1:38 PM Staff D had both hands gloved with blue disposable gloves and was holding a clear bag with a white brief with brown substance on it. Staff D reached into their pocket and pulled out their keys and unlocked the soiled laundry room door. Staff D entered the room, discarded the clear bag into a large trash can, removed their blue gloves from their hands, grabbed their keys out of their pocket,

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left the soiled laundry room door and walked back to the front of the lodge. Staff D was not observed to wash their hands with soap and water or use hand sanitizer after discarding their trash and removing their gloves.

On 02/03/2026 at 1:42 PM, Staff H, Caregiver, used their keys to open the soiled laundry room door and entered with bare hands, holding a clear bag with disposed trash inside. Staff H discarded the bag into the larger trash can in the room and exited the area and walked to the front of the lodge. Staff H was not observed to wash their hands with soap and water or use hand sanitizer after discarding trash.

On 02/03/2026 at 1:50 PM, Staff H was holding a clear bag with a soiled brief, brown substance and discarded blue disposable gloves inside while they was going in and out of multiple residents' rooms looking for Resident 12 (R12) with one gloved hand and one bare hand. Staff H and Staff D entered a vacant residents' room 134 to assist R12 that had wandered in there.

On 02/03/2026 at 1:56 PM, Staff H exited out of the vacant room holding with their gloved hand a clear bag of disposed white brief with brown substance and blue disposed glove inside, pull out their keys with their bare hand and unlock the soiled laundry door. Staff H entered the room and discarded the clear bag of trash and the glove that was on their one hand. Staff H went to the only sink in the area, turned the water on, washed their hands, turned the water off with their clean hands and was unable to dry their hands as there was no paper towels available. Staff H grabbed R15's hands with their wet hands to redirect them out of the soiled laundry room area. At 2:06 PM, Staff H stated they were to wash their hands anytime they touched a resident or were in contact with bodily fluids, urine, feces or germs, after taking off disposable gloves and after throwing away trash. Staff H stated they did not carry hand sanitizer on them, and they preferred to wash their hands with soap, water and paper towels.

On 02/03/2026 at 2:05 PM, Staff U, Caregiver, stated they performed hand hygiene before and after they provided resident care. Staff U stated they used disposable gloves when they provided care and they performed hand hygiene when they took off their disposable gloves. Staff U stated they did not have hand sanitizer on their person as it was not required.

On 02/04/2026 at 12:08 PM, Staff I, Housekeeping, was observed inside Resident 12 (R12)'s room cleaning with disposable gloves on their hands. Staff I took off their gloves and without performing hand hygiene then touched R12's apartment door handle to shut the door. Staff I brought the vacuum and housekeeping cart into the laundry room through the soiled laundry door. Once inside Staff I had not been observed to perform hand hygiene. Staff I stated when they finished cleaning a resident room, they took off their gloves and performed hand hygiene once they completed all their cleaning. Staff I stated when they washed laundry, they performed hand hygiene after they touched soiled items. Staff I confirmed the laundry room sink currently did not have paper towels for staff to use. Staff I stated paper towels were normally at the sink. Staff I stated they were unsure why the Lodge 2 common area did not have soap or paper towels because they restocked supplies weekly on Sundays. Staff I stated bathroom trash cans should

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have trash bags inside of them.

On 02/04/2026 at 3:02 PM, Staff C, Resident Care Coordinator, stated the facility nurse completes in-services with the staff about hand washing and infection control practices. Staff C stated they do not watch staff to ensure they implement infection control practices properly.

On 02/04/2026 at 4:23 PM, observed Staff S, Maintenance, enter the upstairs administrative office with disposable gloves on each of their hands. Staff S stated they had different expectations of when they were supposed to perform hand hygiene. Staff S stated they performed hand hygiene a few times a day. Staff S stated when they were inside of the Lodges they wore disposable gloves. Staff S stated they did not perform hand hygiene every time they took off their gloves.

On 02/05/2026 at 12:33 PM, Staff G, Health Services Director, stated staff were to wash their hands before and after care, before putting on disposable gloves, after removing gloves and after discarding trash or soiled linens. At 3:01 PM, Staff G stated they do not watch the care staff to ensure they are washing their hands and implementing proper infection control practices.

On 02/05/2026 at 1:24 PM, Staff A stated housekeeping department would ensure that all resident care areas were supplied with soap and paper towels. Staff A stated the facility does not have a policy that required staff to carry hand sanitizer, but staff were to wash their hands before entering a residents' room, before and after providing resident care, before leaving any area and before and after glove use.

Hand Hygiene Supplies

On 02/02/2026 at 8:51 AM, observed in Lodge 2's dining room area with the only public sink available in the lodge when the water was attempted to be turned without any running water, no soap dispensed out of the soap dispenser and no paper towels were observed. At 10:05 AM, Staff A stated they were unsure why the water was turned off and confirmed the sink did not have soap and paper towels.

On 02/02/2026 at 9:36 AM and 2:32 PM, observed in Lodge 1's soiled laundry room area with the only sink, there was no paper towels in the dispenser or around available for use.

On 02/02/2026 at 9:42 AM, observed in Lodge 1's dining room area with the only public sink available in the lodge was a beauty salon sink that had a spray nozzle like a shower head. When the water was turned on the water shot out and onto the floor. Staff A stated the facility's beautician only used the sink.

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On 02/02/2026 at 9:52 AM, observed inside Lodge 2's soiled laundry room area that had the only sink available, noted there was no paper towels inside the dispenser. There was a white pillow that was on top of barrel that had smeared brown substance and a package of clean paper towels. Staff A acknowledged the clean paper towels were sitting on a pillow that was soiled.

On 02/02/2026 at 9:56 AM, observed inside the public bathroom there was no paper towels.

On 02/02/2026 at 12:15 PM, observed in Lodge 2 kitchen the hand-washing sink had a pitcher of water and a cup with a white napkin inside. Staff J, Cook, stated the kitchen hand washing sink normally did not have other items inside of it.

On 02/03/2026 at 1:38 PM, observed in Lodge 1 inside the soiled laundry room area with the only sink there was no paper towels available.

On 02/04/2026 at 12:31 PM, observed in Lodge 2 inside the soiled laundry room area with the only sink there was no paper towels available.

On 02/04/2026 at 3:36 PM, observed in Resident 13's bathroom there was a soap dispenser that hung up on the wall. When it was pressed, there was no soap dispensed. There was no other soap available for use in the bathroom area.

Kitchen

On 02/02/2026 at 12:19 PM, observed Staff P, Housekeeping, entered Lodge 2 kitchen, without performing hand hygiene they picked up a pre-poured water cup and delivered it to Resident 13.

On 02/02/2026 at 12:40 PM, Staff J stated they performed hand hygiene whenever they changed tasks or touched another item. Staff J stated they performed hand hygiene when they took off their disposable gloves. At 12:41 PM, Staff N, Food Service Director, entered Lodge 2 kitchen wearing disposable gloves, without performing hand hygiene Staff N picked up a clipboard, Staff N put the clipboard down and took off their disposable gloves.

This is a recurring deficiency previously cited on 05/21/2025 and on 04/27/2023 for subsection (1)(2)(c)(d)(e).

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Plan/Attestation Statement

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

Jodi M. Stephens — Administrator (or Representative)

4/17/26 — 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;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

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

This requirement was not met as evidenced by:

Based on interview, observation and record review, the facility failed ensure both resident buildings and exterior grounds were clean, safe, sanitary and well maintained for 3 of 3 resident areas (Lodge 1, Lodge 2 and Exterior Grounds). These failures resulted in unsanitary, unsafe and unmaintained environment that placed all residents at risk of decreased quality of life and injury.

Findings included...

Lodge 1

Lodge 1 Bathroom

An observation on 02/02/2026 at 9:34 AM, in Lodge 1's public bathroom, showed that the floor was sticky and one could hear audible noises when walking on the floor.

Lodge 1 Laundry Room

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Plan/Attestation Statement

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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;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

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

This requirement was not met as evidenced by:

Based on interview, observation and record review, the facility failed ensure both resident buildings and exterior grounds were clean, safe, sanitary and well maintained for 3 of 3 resident areas (Lodge 1, Lodge 2 and Exterior Grounds). These failures resulted in unsanitary, unsafe and unmaintained environment that placed all residents at risk of decreased quality of life and injury.

Findings included…

Lodge 1

Lodge 1 Bathroom

An observation on 02/02/2026 at 9:34 AM, in Lodge 1's public bathroom, showed that the floor was sticky and one could hear audible noises when walking on the floor.

Lodge 1 Laundry Room

This document was prepared by Residential Care Services for the Locator website.

On 02/02/2026 at 9:38 AM, Lodge 1's laundry room had a hole on the left side of the washing machine that exposed black pipes with no drywall. Staff A stated they were unsure why a hole was in the wall. Staff I, Housekeeping, stated the hole had been in the wall for over six months.

Lodge 1 Kitchen

Record review of the facility document titled, "Maintenance Request Form," dated 01/12/2026, documented Lodge 1's kitchen stove knob had broken off and was marked off as an urgent task. The task had been assigned to Staff S. The date started, the date completed, the total time spent, the material cost, and remarks section were blank.

On 02/04/2026 at 3:33 PM, Lodge 1's kitchen oven did not have the knob that turned the oven on and off. Staff N, Food Service Director, stated they put a work order in to fix the oven's knob, and it had not yet been completed.

Resident 3 (R3)'s Apartment

On 02/02/2026 at 2:33 PM, Department staff turned on R3's kitchenette sink's hot water, no water came out the faucet. Staff H, Caregiver, was present and confirmed that R3's hot water did not work.

On 02/04/2026 at 12:06 PM, Department staff turned on R3's kitchenette sink's hot water, no water came out the faucet.

On 02/10/2026 at 4:00 PM, Collateral Contact 1, R3's Power of Attorney, stated they were unsure why R3 did not have hot water in their kitchenette sink.

Resident 1 (R1)'s Apartment

On 02/02/2026 at 2:47 PM, R1's bathroom vent above their toilet was covered in grey fuzzy substance.

R6's Apartment

Record review of the facility document titled, "Incident Form," dated 12/07/2025, documented R6 had a fall and struck the back of their head against the wall that left a medium sized circular dent on the wall when R6's head made impact.

On 02/02/2026 at 2:40 PM, R6's bathroom shelf had two handheld urinals (a lightweight

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portable device that collected urine) the insides were coated with a light brown substance and a dark brown ring at the opening. The two handheld urinals were observed not cleaned as of 02/05/2026 at 10:08 AM.

On 02/04/2026 at 12:32 PM, Staff G stated that the indented hole next to R6's apartment door near the ground was from R6's fall on 12/07/2025. Staff G stated they were unsure if there was a plan in place to fix the indention in R6's apartment room. Staff S had been observed in the hallway, and they entered R6's apartment room and stated that they saw R6's indention this morning. Staff S stated they did not know about the indented hole previously and they did not have any submitted work orders to fix R6's indentation in their wall.

Resident 7 (R7)'s Apartment

On 02/03/2026 at 1:16 PM, Staff Q stated they were unsure if the residents had a scheduled day where their apartments were cleaned.

On 02/04/2026 at 2:48 PM, an observation of R7's bathroom floor, by the left side of the toilet, by the sink and door, was a missing flooring tile. The flooring in the area had a yellow color.

On 03/03/2026 at 4:10 PM, Staff A stated resident apartments should be cleaned twice weekly.

Resident 4 (R4)'s Apartment

On 02/03/2026 at 1:14 PM, an observation of R4's bathroom showed a grey raised toilet seat with dark brown smeared areas, resembling feces, covering the back and left side on top of the seat.

On 02/04/2026 at 10:02 AM, Collateral Contact 4 (CC4), spouse of R4, stated R4's room was not cleaned all the time and had requested the room to be cleaned but it was never completed. CC4 stated the facility does not clean very well and that CC4 had seen feces on R4's grey raised toilet seat in the past.

On 02/04/2026 at 3:18 PM, an observation of R4's bathroom showed a grey raised toilet seat with dark brown smeared areas, resembling feces, covering the back and left side on top of the seat, same as observed on 02/03/2026.

On 02/05/2026 at 11:30 AM, an observation of R4's bathroom showed a grey raised toilet seat with dark brown smeared areas, resembling feces, covering the back and left side on top of the seat. Staff V, Caregiver, observed the grey toilet riser and stated that

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it was not clean and that housekeeping was to complete a deep clean weekly and caregivers completed day-to-day cleaning.

Resident 17's Apartment

Record review of the facility document titled, "Maintenance Request Form," dated "1/06", documented Resident 17 (R17) requested a bedroom door lock due to male residents entering their room when they used the bathroom. The maintenance slip was not marked off as urgent or not urgent. The "for office use only" section that showed who the task was assigned to, the date started, the date completed, the total time spent, the material cost, and remarks section were blank.

On 02/04/2026 at 3:04 PM, Staff C stated that R17 wanted a lock on their apartment door because a male resident kept entering their room and they wanted privacy when they were in the bathroom.

Observation on 02/04/2026 at 3:25 PM, apartment room [redacted] outside door handle did not have a lock.

On 02/05/2026 at 10:12 AM, R17 stated when they were in their previous apartment room, they requested a key and a door that locked so that male residents could not enter their room without permission. R17 stated male residents entered their room and deliberately peed on their bathroom floor and laid down in their roommate's bed. R17 stated they did not feel safe and would scream at the male resident to get out. R17 stated that they had a hard time sleeping at night because they did not know what was going to happen to them once they did.

On 02/05/2026 at 10:20 AM, Staff C stated they made a work order on R17's behalf for them to get a lock and key because a male resident kept entering R17's room and urinating on their floor.

Resident 18's Apartment

Record review of the facility document titled, "Maintenance Request Form," dated 11/06/2025, documented Resident 18 (R18)'s closet door fell off the hinges. The maintenance request was marked off as urgent and the "for office use only" section that showed who the task was assigned to, the date started, the date completed, the total time spent, the material cost, and remarks section were blank.

Record review of the facility document titled, "Maintenance Request Form," dated 11/29/2025, documented R18's closet door had been broken and was on the floor. The maintenance request was marked off as urgent. Staff S had been assigned to the task. It was documented Staff S started the task on 11/26/2025 and it was completed

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11/26/2025.

Record review of the facility document titled, “Maintenance Request Form,” dated 12/14/2025, documented R18’s closet door was in the entry way of R18’s room and needed to be placed back on the closet. The maintenance slip was not marked off as urgent or not urgent. The “for office use only” section that showed who the task was assigned to, the date started, the date completed, the total time spent, the material cost, and remarks section were blank.

On 02/04/2026 at 3:30 PM, Staff C opened R18’s apartment door and confirmed R18’s right side of their closet door was off the hinges and not present.

Resident 19 (R19)’s Apartment

On 02/04/2026 at 3:41 PM, R19 stated the facility recently hired housekeeping staff. R19 stated previously the laundry staff would come and clean their apartment bathroom on an inconsistent basis. R19 stated at times it was cleaned once a week and other times it was cleaned once a month. R19 stated to their knowledge the new housekeeping staff had yet to come into their apartment to deep clean. R19 stated at times the facility staff vacuumed their room because they personally requested it. Inside of R19’s bathroom the vent above the toilet had grey fuzzy substance on it.

Lodge 2

Lodge 2 Community Room

On 02/02/2026 at 8:51 AM, Lodge 2’s kitchenette sink’s handle was turned and no water dispensed out of the faucet. The drain had loose corn kernels inside and flying bugs came out of the drain.

On 02/02/2026 at 10:05 AM, Staff A stated they were unsure why the water was off in the kitchenette and it was not common for corn and bugs to be in the drain.

On 02/02/2026 at 10:03 AM, Lodge 2’s standing refrigerator in the common area freezer had a red substance on the inside of the freezer door and shelf. Staff J, Cook, stated the red substance was from a popsicle that melted and that it needed to be cleaned.

On 02/02/2026 at 12:29 PM, Staff J stated the kitchen staff cleaned the facility refrigerators a couple of times a month.

Lodge 2 Laundry Room

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On 02/02/2026 at 9:53 AM, Lodge 2's laundry room vent above the washer and dryer had grey fuzz that protruded out of the vent. Staff A stated they were unsure how often the facility staff cleaned the vents. Staff P, Housekeeping, stated they dusted facility vents when they had a chance.

Lodge 2 Bathroom

On 02/02/2026 at 9:58 AM, Lodge 2's public bathroom did not have paper towels in the paper towel dispenser. The trash can did not have a trash bag that lined the inside of the trash can and there were used paper towels inside of it.

Lodge 2 Kitchen

Record review of the facility document titled, "Daily Task List," dated "02/2026," documented that daily cleaning included the microwave, if used, and carts.

During an observation on 02/02/2026 at 12:23 PM, Lodge 2's kitchen had a grey rolling cart with unknown brown substance and orange liquid on top of it. A pitcher of juice was on top of the cart underneath the brown substance and orange liquid. The cart's handlebar had sections that were coated in an unknown brown substance. The grey storage shelf had black handles that had orange and brown substances splattered next to it. The kitchen's hand-washing sink and fire extinguisher had flying bugs observed next to them. The kitchen cabinet above the stove had the left side knob missing. The white cupboard had sections that were coated in brown. The microwave had unknown food particles splattered on the inside door and in the back of the microwave.

On 02/02/2026 at 12:23 PM, Staff J stated it was not common for flying bugs to be in the kitchen and was unsure how long the cabinet did not have a functional knob. Staff J stated they had a daily task sheet the kitchen staff were supposed to use as a cleaning reference.

Resident 2 (R2)'s Apartment

On 02/05/2026 at 9:45 AM, upon entering R2's room there was a strong pungent odor that smelled like urine.

Resident 13 (R13) call light

Record review of the facility document titled, "Maintenance Request Form," dated 01/27/2026, documented, call light "A" for R13 had been ripped off the wall. The

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maintenance slip was marked urgent. There was nothing else documented on the maintenance request form.

On 02/04/2026 at 3:32 PM, observed in R13's apartment, above their bed on the wall, were two holes and no call light box. Observed on the R13's bedside table was a cream-colored call light box that was upside down with the activation buttons inaccessible and the red pull string was underneath multiple books inaccessible and difficult to visual.

On 02/04/2026 at 4:23 PM, Staff S stated that "A" side of the room was on the left and they had addressed the maintenance request form for R13 dated 01/27/2026 and hung the call light back up. Staff S stated they addressed maintenance request forms the same day they received them.

On 02/05/2026 at 10:11 AM, in the hallway, near R13's apartment door, there was a pungent ammonia smell that resembled urine. In R13's apartment on the wall above their bed was two holes and no call light box. Noted the call light box was still upside down on the bedside table.

Resident 5 (R5)'s Apartment

Review of facility resident records for Resident 5 showed that they admitted to facility on [redacted]/2024.

On 02/03/2026 at 1:04 PM, R5's kitchenette's cold and hot water did not dispense water when the faucet was turned on. R5 stated the water had not worked since they admitted to the facility. R5 stated their hand-held shower head was broken and when it was turned on it flooded their bathroom floor. R5 stated they had expressed their concerns to the facility staff. R5 stated they were taught how to deal with the problem by the facility staff using extra towels to soak up the water versus fixing the problem. When R5's handheld shower nozzle was turned on water squirted out of the base in all directions.

On 02/03/2026 at 1:16 PM, Staff Q, Caregiver, stated that they did not know that R5's handheld shower was broken. Staff Q stated they were not aware R5's kitchenette water did not work.

On 02/03/2026 at 1:23 PM, Staff M, Medication Technician, stated R5 had not mentioned their hand-held shower being broken to them. Staff M stated if there ever was a concern they had maintenance slips they filled out and turned in. Staff M stated they did not know why R5's kitchenette water did not work. Staff M said there were other resident rooms where their kitchenette water did not work or only one side of the water turned on. Staff M stated water not working had been ongoing issue since they started working for the facility [09/17/2024].

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On 02/03/2026 at 2:50 PM, Staff A and Staff C stated they were unsure of any concerns regarding water not working throughout the facility and they would have to ask Staff S who was not available. Staff A stated the facility filled out work orders on paper and, after one to two weeks, the management team reviewed the work orders, and would review the plan to fix any issues that arise. Staff A stated Staff S turned in the completed work orders to them.

Exterior Grounds

An observation on 02/03/2026 at 10:45 AM, in front of Lodge 2, showed multiple blue wrappers and other various items of trash on the ground. Further observation of the sidewalk, outside of the fence, there were two large piles of a brown substance that resembled feces, one of the piles had white tissue paper on it.

On 02/03/2026 at 2:12 PM, observed Staff H exiting Lodge 1's front doors, carrying trash to the dumpster. Staff H walked past the front doors of Lodge 2 and to the right near the wooden fence were two piles of a brown substance on the sidewalk, multiple blue wrappers and other various pieces of trash.

On 02/03/2026 at 2:12 PM, Staff H stated Resident 14 (R14) was known to throw feces and other garbage over the fence and acknowledged that the two brown piles were feces. Staff H continued to the dumpster where multiple items were scattered about, including a white rolling trash can in front of the dumpster with loose disposable blue gloves that covered the bottom layer of the bin, two wheelbarrows that rested against the fence, two wooden plank boards, a dresser with no drawers, a washing machine that was in pieces, a wooden coffee table, twin size mattress that had pine needles and leaves on top of it, under the mattress was a wooden crate, and four rusted wheel rotors and a muffler.

O2/04/2026 at 12:18 PM, observed inside the inner courtyard of Lodge 2, next to the door closest to the fence, near the parking area by the water spicket in the garden area, there was a large pile of brown feces with wet white tissue near the sidewalk, a brown wrapper of "grandma cookies" chocolate chip, and a empty red package and another pile of brown substance closer to the fence with a clear plastic square container on top of it. At 3:40 PM the two piles of feces were still in the inner courtyard.

On 02/04/2026 at 4:23 PM, Staff S stated they were aware, since they started employment, that R14 disposed of their feces over the fence outside of Lodge 2. Staff S stated that they only walked the courtyards weekly and was unaware that there was feces near the fence in the inner courtyard. Staff S stated all staff were responsible for cleaning the trash and R14's feces when observed.

On 02/05/2026 at 10:12 AM, observed in the inner courtyard outside of the door of Lodge 2, near the fence and parking lot, the two piles of feces that were observed on

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02/04/2026, and an additional pile of feces located closer to the bottom of the fence. Observed near the top of the fence was a large area of brown and white matted substance stuck to the fence boards.

On 02/05/2026 at 12:33 PM, Staff G stated they were aware R14 disposed of their feces over the fence and that maintenance was responsible for cleaning up after R14. Staff G stated the fence, and surrounding areas should be checked daily for cleanliness.

On 02/05/2026 at 1:20 PM, Staff A stated they walked through Lodge 1, Lodge 2 and the interior courtyard area daily every morning. Staff A stated they did not walk through the exterior grounds of the facility. Staff A was unsure if Staff S completed exterior walkthroughs of the facility. Staff A stated they were aware R14 threw their feces and trash over the fence from time to time. Staff A stated all facility staff should check the exterior of the facility for feces when they took the trash out. Staff A stated that, to their knowledge, R14 did not leave feces inside the Lodge 2 courtyard and it had not been reported.

On 02/05/2026 at 3:03 PM, Staff A did a walkthrough with Department staff, following the route they completed daily. When Staff A approached Lodge 2's furthest door in the inner courtyard near the fence closest to the parking lot, Staff A stated, "I see what you mean," and acknowledged there was trash and multiple piles of feces.

On 02/05/2026 at 3:03 PM, Staff A stated they did not have a chance to complete the walkthrough today and that they did not see the feces on 02/04/2025 and acknowledged that there were residents that wander and walk barefoot outside.

Facility Staff Interviews

Record review of the facility document titled, "Maintenance Request Form," dated 12/07/2025, documented the hallway near room 139 had feces stains on the wall and floor and the facility staff requested the carpets be cleaned. The maintenance request was not marked off as urgent or not urgent. The for office use only section that showed who the task was assigned to, the date started, the date completed, the total time spent, the material cost, and remarks section were blank.

On 02/04/2026 at 12:08 PM, Staff I, Housekeeping, stated the facility staff did their best to try to clean every resident's room daily. Staff I stated they vacuumed, collected trash, if needed they made the bed and wiped down counters. Staff I stated the facility staff did their best to deep clean every resident's room daily which also entailed cleaning the resident's bathroom, cleaning the floors, dusting and wiping down bed frames. Staff I stated they did not have a set schedule of when they deep cleaned resident apartments. Staff I stated they did not know why Lodge 2 community room's kitchen sink water was turned off. Staff I stated Staff S was the person responsible to

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clean vents throughout the community. Staff I stated the housekeeping staff would clean the outside perimeter, but Staff S cleaned the inside of vents. Staff I looked at the hole in the laundry room next to the washing machine and stated the hole had been there for over six months. Staff I said they were unsure why Lodge 2's public bathroom did not have trash bag inside of the trash can. Staff I stated the housekeeping staff and caregiver staff were responsible to make resident beds daily and take out their trash.

On 02/04/2026 at 12:38 PM, Staff S stated there were work order forms located in Lodge 1 and Lodge 2 medication rooms and facility staff submitted needed work orders. Staff S stated they checked to see if they had new work orders daily. Staff S stated they kept the paper copy of the work order until the work was finished and then turned the work order into Staff A. Staff S stated they were unsure why Lodge 2 community room kitchenette sink did not have running water and that the water had been turned off since they started working for the facility [11/04/2025]. Staff S stated they were unsure why there was a hole in the wall with exposed pipes next to the washing machine in Lodge 1's laundry room. Staff S stated they thought it was from a leak, but it happened before they started working for the facility. Staff S did not have a current plan to fix the hole and stated they had to figure out why the hole was made in the first place and repair it from there. Staff S stated to their knowledge they do not have guidance on how often vents in the facility were to be cleaned. Staff S stated they did not have any work orders or that they were aware Lodge 2 kitchen had a cabinet knob that was missing. Staff S stated they did not have any work orders or knowledge that R3's kitchenette did not have running hot water. Staff S stated they did not have knowledge that R5's kitchenette did not have running water. Staff S stated they were not aware R1's bathroom vents were fuzzy. Staff S stated they did not have a plan in place to remove the miscellaneous items next to the exterior trash bin. Staff S stated the car parts next to the outside trash were present before they started working for the facility in November.

On 02/04/2026 at 1:55 PM, Staff A stated Staff S was not trained on their maintenance director responsibilities when Staff S was on boarded. Staff A stated Staff S and Staff A learned the maintenance responsibilities together. Staff A stated there were no timeline guidelines for when work orders needed to be completed. Staff A stated if the work order was time sensitive it should have been marked on the work order. Staff A stated sometimes multiple facility staff would create a work order for the same issue. Staff A was unsure if the 11/06/2025 work order for R18's closet door being off the hinges was completed. Staff A stated the 12/07/2025 work order for feces stains on the wall and floor near room 139 had been completed. Staff A stated they had not followed up with Staff S regarding uncompleted work orders. Staff A stated they were not sure why R3 and R5's kitchenette water did not work. Staff A stated they were unsure if there was a leak and the water was turned off. Staff A stated there was not a current plan in place to get rid of the miscellaneous items outside by the trash.

On 02/04/2026 at 4:23 PM, Staff S reiterated that work orders were generated from other facility staff members. Staff S stated when they arrived in the morning, they went into Lodge 1 and Lodge 2 medication rooms and picked up work orders. Staff S stated R18's closet door was still off the hinges because they had a hard time finding the needed parts. Staff S stated they put R13's call light back on. Staff S stated Lodge 1 kitchen oven knob was broken and they haven't found the replacement part. Staff S

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stated they were sure the feces on the wall and floor were cleaned, they verbally asked was the maintenance request form assigned to me, they reviewed that the work order was not assigned to anyone and stated they would of delegated the task to Staff I. Staff S stated they had knowledge that R14 picked up their feces and threw it over the fence. Staff S stated they tried to do weekly rounds of the exterior of the facility.

This is a recurring deficiency previously cited on 03/28/2025 and 04/27/2023 for subsections (1)(a)(c).

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 5/18/2026.

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

Jodi N. Stephens
Administrator (or Representative)

4/17/26
Date

WAC 388-78A-2210 Medication services.

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

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

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

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

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

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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to dispose of expired medications and failed to ensure controlled substance (narcotic) medications

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stated they were sure the feces on the wall and floor were cleaned, they verbally asked was the maintenance request form assigned to me, they reviewed that the work order was not assigned to anyone and stated they would of delegated the task to Staff I. Staff S stated they had knowledge that R14 picked up their feces and threw it over the fence. Staff S stated they tried to do weekly rounds of the exterior of the facility.

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_____ _____

Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to dispose of expired medications and failed to ensure controlled substance (narcotic) medications

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were accounted for in 2 of 2 medication carts (Lodge 1 and 2 medication carts), failed to ensure staff did not administer expired medications (insulin) for 2 of 3 residents (Resident 9 and 6), failed to ensure medication orders were clear and specific for 4 of 8 residents (Resident 7, 2, 11 and 8), and failed to notify the physician when 1 of 1 resident's (Resident 5 [R5]) refused medications. These failures placed all residents at risk for improper handling, disposal, storage, and administration of medications and placed residents at risk for harm, medication errors, misuse of medication and adverse reactions due to expired medications and inconsistent and/or improper medication management.

Findings included…

Expired Controlled Substances Medications

Record review of the facility policy titled "Medication, Destruction," dated 02/15/2024, documented the facility was to dispose of resident medications as soon as the medication expired or was discontinued.

Record review of the facility policy titled "Managing Controlled Medications," dated 02/15/2024, documented controlled substances (narcotic) received from a pharmacy wound be entered onto the narcotic administration record log (narcotic log). The page number of the narcotic log would be handwritten on the medication bottle or punch card. The narcotic log would be kept in the locked drawer of the medication cart. When a narcotic was discontinued, the medication would be promptly destroyed by a licensed nurse and a witness and recorded. All narcotic medications would be counted at the change of each shift. The count would be verified by comparing the last recorded amount remaining on the narcotic log with the actual number remaining in the punch-card or bottle. Once the narcotic was verified both by the person counting and the person witnessing the count, they would sign the narcotic log.

An observation on 02/04/2026 at 12:45 PM, of Lodge 2's medication cart (med cart), showed a narcotic locked box were narcotic medications cards were forward facing with the resident's pharmacy prescription label and medication pills easily observed in the front. Observed there was 32 narcotic medication cards that were turned around backwards.

On 02/04/2026 at 12:45 PM, Staff M, Medication Technician, stated the narcotic medication cards that were backwards were either expired medications or were for residents that had passed away.

Record review on 02/04/2026 of Resident 26's narcotic medication card showed there were eight tablets remaining, was logged on page 56 of the narcotic log, and that the narcotic medication expired on 05/13/2025.

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Record review on 02/04/2026 of the narcotic log, located on the med cart, showed that the entry on page 56 was for Resident 14 (R14) and the remaining medication count was zero.

On 02/04/2026 at 12:45 PM, Staff M, stated since the narcotic card for page 56 was expired, it would be in a different narcotic log. Staff M produced three narcotic logs.

Record review on 02/04/2026 of Resident 27's narcotic medication card showed that it was logged on page 122 of the narcotic log and had 28 tablets remaining.

Record review on 02/04/2026 of the narcotic log, on page 122, showed no documentation of an entry of a narcotic medication and was blank.

On 02/04/2026 at 12:45 PM, Staff M stated that they were trained to not count the narcotic medications, and do not count narcotic medications that are turned backwards in the narcotic locked box located in the med cart. Staff M stated that they assumed Staff G, Health Services Director, counted the narcotic medications that are turned backwards in the narcotic locked box located in the med cart to ensure they were all accounted for. Staff M stated that the narcotic medications in the med cart had been there for a long time waiting to be disposed of by the licensed nurse.

Review of narcotic log number five, one of three past narcotic logs, documented the last night the narcotics in that log were last counted was on 07/31/2025. Staff M stated they did not count the controlled substance cards that were turned backwards that morning.

An observation on 02/04/2026 at 1:10 PM, of Lodge 1's med cart narcotic lock box, showed seven narcotic medication punch cards turned backwards, five liquid narcotic bottles and two pill bottles all in the back of the box, behind a gray plastic divider.

On 02/04/2026 at 1:10 PM, Staff C, Resident Care Coordinator (RCC), stated that they were working and in charge of Lodge 1's medication cart that contained the narcotic lock box for this shift. Staff C stated that all the narcotic medications in the narcotic lock box, behind the grey plastic divider, needed to be destroyed due to being expired or that they belonged to residents that have moved out. Staff C stated that Staff AA, Medication Technician, would count narcotic medications of residents who have moved out once or twice a week. Staff C stated that they did not count the narcotic medications behind the grey plastic divider when taking over the medication cart.

On 02/03/2026 at 1:52 PM, Staff G and Staff O, Director of Operations, acknowledged that all controlled substances locked in the medication carts were to be counted every shift by the oncoming and off going scheduled medication technicians.

Insulin Administration

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Record review of the Consumer Medication Safety document titled “Storage of Insulin,” dated 2026, documented that facilities should mark the date insulin pens were opened and first used on the label. Insulin expired 28 days after opening and facilities must throw away expired insulin.

Record review of R9’s Medication Administration Record (MAR), dated 02/01/2026 through 02/05/2026, documented an order for Lispro insulin (medicated injection to help lower high blood sugar levels quickly) pen to inject three times daily. Review of the MAR documented R9 received lispro insulin on 02/01/2026 and 02/03/2026.

An observation on 02/04/2026 at 12:41 PM, of Lodge 2’s medication cart, showed Resident 9 (R9)’s lispro insulin pen was opened on 12/16/2025. Staff M, Medication Technician, was unaware how long insulin pens or cartridges were good for after opened. Staff M stated they went by the expiration date printed on the insulin pen. Staff M stated they had administered R9's insulin today, from the insulin pen opened 12/16/2025.

Record review of R6’s MAR, dated 02/01/2026 through 02/03/2026, documented R6 had an order for insulin to be administered at bedtime as needed and a scheduled insulin every morning. The MAR showed R6 received the as needed insulin on 02/01/2026 and the daily insulin on 02/01/2026, 02/02/2026 and 02/03/2026.

An observation on 02/04/2026 at 1:06 PM, of Lodge 1’s medication cart, showed Resident 6 (R6) had two different insulin pens in the medication cart, one was dated as opened on 12/26/2025, the other did not have a date.

On 02/04/2026 at 1:06 PM, Staff G stated that medication technicians were to write the date insulin pens were opened on the pen or on the prescription label. Staff G acknowledged R6’s insulin pens were expired.

On 02/04/2026 at 1:19 PM Staff C stated they did not check R6’s insulin pens dates prior to administering the insulin that morning. Staff C stated Staff AA did a weekly audit of insulin pen dates and that was the only time the insulin pens were checked.

Medication Orders

Resident 7 (R7)

Record review of R7’s MAR, dated 02/01/2026 through 02/03/2026, documented an order for triamcinolone cream (medicated cream to help reduce inflammation, redness and swelling) to apply three times daily to affected areas. The directions did not list

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what “affected area” meant, specific directions or location on the body.

Resident 2 (R2)

Record review of R2’s MAR, dated 02/01/2026 through 02/03/2026, documented wound care cleanser with directions to use as directed to clean wound on forehead. There was no specific directions as how to use the wound cleaner or how often.

Resident 11 (R11)

Record review of R11’s MAR, dated 02/01/2026 through 02/03/2026, documented they had an order for clotrimazole with betamethasone (medicated cream to treat fungal skin infections) to be applied to affected area every day. There was no specific directions as to where on the body to apply R11’s prescribed medicated cream. R11 had an order for zinc oxide (cream to help protect the skin) forty percent ointment to apply three times daily with each diaper change. There was no specific direction as to where on R11’s body the ointment was to be applied. R11’s order for acetaminophen (medication to help treat pain, discomfort and reduce fever) to administer every four hours as needed. There were no specific directions as to why they were to administer the medication.

Resident 8 (R8)

Record review of R8’s MAR, dated 08/01/2025 through 08/31/2025, documented they had an order for acetaminophen take one to two tablets every eight hours as needed for pain. The order was not specific as to when they would give one tablet or two tablets. R8 had an order for gabapentin (medication to help treat nerve pain) take two to three capsules every day at bedtime as needed. The order did not have specific instructions when to give one or two capsules and reason as to why to give the medication.

Medication Refusal

Record review of the facility’s policy, “Medication Refusal,” dated 02/15/2024, documented when a resident refused their medication they would be encouraged to reconsider the refusal. If the resident continued to refuse the refusal and the potential side effects of not taking the medication would be evaluated and documented by a licensed Nurse. The resident’s primary care provider and their responsible party would be notified of the refusal. If a licensed nurse was not available and the primary care provider had not given prior notification instructions the primary care provider would be informed of the refusal each time. The primary care provider notification must be documented in the resident’s health record by the licensed nurse. If there was a continued pattern of medication refusal the licensed nurse would discuss the possibility of alternative medications, alternate administration, or discontinuing medication with the primary care provider and the resident’s representative.

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Resident 5 (R5)

Record review of R5's document titled, "WA Health and Service Evaluation Results and Service Plan," dated 11/03/2025, documented R5 moved into the facility on 12/20/2024 and had a diagnosis of [redacted]. The facility staff stored and assisted with R5's self-administration of their medication.

Record review of R5's document titled, "eMAR (electronic medication administration record)," dated 12/01/2025 through 12/31/2025, documented R5 had an order for divalproex sprinkle (a mood stabilizing medication) two times a day with meals and refused 25 of 62 dosages. R5 had an order for olanzapine (a mood stabilizing medication) two times a day and refused 24 of 62 dosages. R5 had an order for trazodone (a mood stabilizing medication) once a day and refused nine of 31 dosages. R5 had an order for nitrofurantoin monohyd macro (an antibiotic used to treat and prevent urinary tract infections) and refused six of 14 dosages.

Record review of R5's document titled, "eMAR," dated 01/01/2026 through 01/31/2026, documented R5 had an order for divalproex sprinkle and refused 11 of 62 dosages. R5 had an order for olanzapine and refused 12 of 62 dosages. R5 had an order for trazodone and refused 7 of 31 dosages.

On 02/04/2026 at 11:05 AM, R5's orders of when their primary care provider wanted to be notified of refused medications were requested to review.

On 02/04/2026 at 12:19 PM, Staff A, Executive Director, stated there were no orders for when R5's primary care provider wanted to be notified when R5 refused their medication.

On 02/05/2026 at 8:16 AM, R5's 12/01/2025 through 02/05/2026 notifications to their primary care provider were requested to review.

Record review of R5's document titled, "Physician Communication," dated 12/21/2025 documented R5 refused their medications and care at times. There was no other documentation to review that R5's primary care provider had been notified when they missed their medications in December and January.

On 02/04/2026 at 4:49 PM, Staff K, Medication Technician, stated if a resident refused their medication, they attempted three times before they documented on the eMAR that the resident refused. Staff K stated they notified Staff A, Staff C, Resident Care Coordinator, the residents representative, and the residents primary care provider via fax.

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On 02/04/2026 at 4:52 PM, Staff C stated if a resident missed or refused their medication, they attempted three times before they documented on the eMAR that the resident refused. Staff C stated they notified Staff G. Staff C stated majority of the residents saw the facility home provider, the provider was at the facility often, and they notified the provider in person when a resident missed or refused their medication. Staff C stated if they do not verbally inform the provider then the resident's provider would be notified via fax. Staff C stated R5 had a history or refusing their medications.

On 02/05/2026 at 10:20 AM, Staff C clarified that when they verbally informed the home provider that a resident missed or refused their medication, they did not document their conversation anywhere.

On 02/05/2026 at 12:33 PM, Staff G stated if a resident refused their medication the facility staff should attempt three times before they documented the resident refused their medication. Staff G stated if a resident missed their medication for more than one shift they should be notified and the residents primary care provider should be notified. Staff G stated R5 refused their medication often. Staff G stated the facility staff should document that they notified the resident's primary care provider.

This is a recurring deficiency previously cited on 04/27/2023 under subsections (1)(a).

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 5/18/2026.

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

Jodi M. Stephens
Administrator (or Representative)

4/17/2026
Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

This document was prepared by Residential Care Services for the Locator website.

On 02/04/2026 at 4:52 PM, Staff C stated if a resident missed or refused their medication, they attempted three times before they documented on the eMAR that the resident refused. Staff C stated they notified Staff G. Staff C stated majority of the residents saw the facility home provider, the provider was at the facility often, and they notified the provider in person when a resident missed or refused their medication. Staff C stated if they do not verbally inform the provider then the resident's provider would be notified via fax. Staff C stated R5 had a history or refusing their medications.

On 02/05/2026 at 10:20 AM, Staff C clarified that when they verbally informed the home provider that a resident missed or refused their medication, they did not document their conversation anywhere.

On 02/05/2026 at 12:33 PM, Staff G stated if a resident refused their medication the facility staff should attempt three times before they documented the resident refused their medication. Staff G stated if a resident missed their medication for more than one shift they should be notified and the residents primary care provider should be notified. Staff G stated R5 refused their medication often. Staff G stated the facility staff should document that they notified the resident's primary care provider.

This is a recurring deficiency previously cited on 04/27/2023 under subsections (1)(a).

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-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

This document was prepared by Residential Care Services for the Locator website.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents, or their responsible parties signed the Washington (WA) Health and Service Evaluation Results and Service Plan (facility's version of the negotiated service agreement (NSA)) for 2 of 7 sampled residents (Resident 1 and 3). This failure placed residents and their responsible party's at risk of being denied the opportunity to negotiate and agree to the resident's care needs and services being provided.

Findings included…

Record review of the facility's policy titled, "Negotiated Service Agreement-NSA (also see Resident Service Plans)," dated 02/15/2024, documented the NSA must be reviewed and signed at least annually by a community representative, the resident and or the resident representative.

R1

Record review of R1's document titled, "Resident Face Sheet," undated, documented the facility admitted R1 on [redacted]/2025.

Record review of R1's document titled, "WA Health and Service Evaluation Results and Service Plan," dated 02/02/2026, documented it was a move in assessment and there were no documented signatures from the facility representative, R1 and Collateral Contact 3 (CC3), R1's Power of Attorney.

On 02/04/2026 at 1:10 PM, CC3 stated that on 02/03/2026, Staff G, Health Services Director, called them and sent them R1's NSA to review and sign electronically. CC3 stated they needed to look over the NSA with their spouse before they signed that they agreed to the services.

R3

Record review of R3's document titled, "Resident Face Sheet," undated, documented R3 moved into the facility on [redacted]/2025.

Record review of R3's document titled, "WA Health and Service Evaluation Results and Service Plan," dated [redacted]/2025, documented it was a move in assessment and no there were no documented signatures from the facility representative, R3 and Collateral Contact 1 (CC1), R3's Power of Attorney.

Record review of R3's document titled, "WA Health and Service Evaluation Results and

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Service Plan," dated 09/11/2025, documented it was a 30-day assessment and there were no documented signatures from the facility representative, R3 and CC1.

Record review of R3's document titled, "WA Health and Service Evaluation Results and Service Plan," dated 12/11/2025, documented it was a quarterly assessment and there were no documented signatures from the facility representative, R3 and CC1.

On 02/05/2026 at 12:33 PM, Staff G stated that whenever they created an NSA, they sent the NSA via email to the resident's representative for them to review and sign. Staff G stated once the resident representative sent the signed NSA back to them, they signed the NSA. Staff G stated that some resident representatives came in person to review the NSA. Staff G stated that when this occurred the resident representative took the NSA home for additional review before they returned it signed.

This is a recurring deficiency previously cited on 04/27/2023 under subsections (1)(2).

Plan/Attestation Statement

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

Jodi M. Stephens — Administrator (or Representative)

4/17/26 — Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document in the resident's Negotiated Service Agreement (NSA) the plan to provide assistance with activities of daily living (ADLs), the residents' preferences on how services would be

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Service Plan," dated 09/11/2025, documented it was a 30-day assessment and there were no documented signatures from the facility representative, R3 and CC1.

Record review of R3's document titled, "WA Health and Service Evaluation Results and Service Plan," dated 12/11/2025, documented it was a quarterly assessment and there were no documented signatures from the facility representative, R3 and CC1.

On 02/05/2026 at 12:33 PM, Staff G stated that whenever they created an NSA, they sent the NSA via email to the resident's representative for them to review and sign. Staff G stated once the resident representative sent the signed NSA back to them, they signed the NSA. Staff G stated that some resident representatives came in person to review the NSA. Staff G stated that when this occurred the resident representative took the NSA home for additional review before they returned it signed.

This is a recurring deficiency previously cited on 04/27/2023 under subsections (1)(2).

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-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document in the resident's Negotiated Service Agreement (NSA) the plan to provide assistance with activities of daily living (ADLs), the residents' preferences on how services would be

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provided and updates to the plans related to incidents or injuries for 6 of 9 sampled residents (Resident 7, 4, 8, 1, 6 and 3). These failures placed the residents at risk for unmet care needs and care and services not being provided per the NSA.

Findings included…

Record review of the facility's policy titled “Negotiated Service Agreement,” dated 02/15/2024, documented the service plan would contain a description and clearly define respective roles and responsibilities related to the residents care and service needs. The policy documented that the description should include a plan to monitor and provide interventions for current risks to the residents’ health and safety identified in resident assessments, include how and when activities of daily living needs would be met and how the resident’s preferences would be honored. The policy documented that the NSA would include frequency and approximate time of day the outlined services would be provided.

Record review of the facility’s policy titled “Temporary Service Plans,” dated 02/14/2025, documented each time there was a change in a resident’s care approach, an appropriate temporary service plan (TSP) form would be completed, and all caregivers were responsible to read and sign the TSP. A TSP was to be completed each time there was a care approach change for a resident. Staff were to follow the approaches as specified on the residents’ TSP’s.

Record review of the facility’s policy titled “Change of Condition,” dated 09/24/2024, documented the medication technician, resident care coordinator or the Health Service Director (HSD) would determine the type of intervention and if follow-up was indicated. Any nursing interventions or new physician orders implemented would be documented on the TSP.

Resident 7 (R7)

Record review of R7’s NSA, dated 01/25/2026, documented R7 moved into the facility on [redacted]/2014 with multiple medical diagnoses that included [redacted] and [redacted]. R7 required minimal assistance with cues and prompts from staff to use a walker and for transfers. R7 was to get a shower one to two times weekly but preference for shower days or times was not noted.

Record review of facility resident record titled “After Visit Summary (AVS),” dated 01/30/2026, documented R7 was seen at the emergency department after a fall and had sustained a fracture to their shoulder. The AVS documented that R7’s arm should be immobilized in a sling and ice should be used for pain management.

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Record review of R7's TSP, dated 02/03/2026, documented R7 was at an increased risk for falls with the limited use of the left arm. Staff would assist R7 to complete activities of daily living as needed. The medication technicians would administer pain medication as ordered and monitor for effectiveness and side effects. TSP did not state that R7 needed full assistance with dressing, had the inability to use a walker, and required the use of wheelchair.

Resident 4 (R4)

Record review of R4's NSA, dated [redacted]/2026, documented R4 moved into the facility on 05/30/2025, had mild cognitive impairment and was able to effectively make their needs known. R4 required extensive hands-on assistance with transfers or changes in positioning, dressing, toileting and personal grooming. R4 required hands on extensive assistance with showers one to two times weekly but preference for shower days or times was not noted. NSA showed no documentation that R4 required side rails or half rails on the bed.

An observation on 02/03/2026 at 12:55 PM, showed that R4's bed had side rails on both sides of the bed. The side rail against the wall was in the up position. R4 was wearing a black sling to the left arm.

On 02/03/2026 at 12:55 PM, R4 stated that they were independent with personal care needs but required assistance with showers. R4 stated their arm was injured and they were given a sling to wear after going to the urgent clinic for an evaluation. R4 stated that they did not use side rails to move around in bed. R4 stated that they were able to propel around in their wheelchair independently except needing assistance from staff for longer distances. R4 stated they did not wear their dentures as they did not fit and transferred themselves to the toilet independently. R4 stated they were to get two showers a week in the evenings with the assistance of staff.

On 02/05/2026 at 10:43 AM, Staff V, Caregiver, stated R4 required one-person minimal assistance with showers, housekeeping, and occasional assistance with toileting and other ADLs, otherwise was independent with ADLs.

Resident 8 (R8)

Record review of R8's NSA, dated 08/06/2025, documented R8 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted] R8 had an increased risk for falls, required two-person assistance with transfers, used a walker for ambulation, wore non-skid socks and well-fitting shoes when out of bed, environment kept free of obstacles and to report any change in behavior, strength or mobility to the health services director. R8 had multiple deep

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purple and red bruises on both buttocks. There was visible redness, swelling and start of open sore skin breakdown and a dime size black spot that was open. There were no interventions listed for the staff to implement to reduce pain and prevent further skin breakdown.

Record review of R8's progress note, dated 08/06/2025 at 12:48 PM, documented that a TSP was implemented related to a change of condition because of a new skin breakdown on R8's buttocks.

Record review of R8's progress note, dated 08/11/2025 at 5:46 AM, documented R8 was bleeding from their buttock wound and the licensed nurse was notified. R8 had gone to the emergency room on 08/10/2025 with new orders to have a negative pressure wound therapy (a device that helps skin wounds heal) applied to the buttocks wound. R8 returned to the emergency room for their bleeding buttocks wound. R8 returned to the facility at 10:59 PM, with new orders for wound care as soon as possible. The facility was unable to provide a TSP for the change in buttocks wound bleeding.

Record review of R8's progress note, dated 08/21/2025 at 8:00 AM, documented the buttock wound had worsened and exhibited yellow and black tissue, caused discomfort and that R8 was sent to the emergency department and returned to the facility.

Record review of the facility's document titled "Resident Incident Log," dated 07/01/2025 through 08/31/2025, documented R8 had a fall on 07/29/2025, 08/01/2025 at 3:30 PM and 6:00 PM, 08/02/2025, 08/03/2025, 08/04/2025, 08/07/2025, 08/14/2025 and 08/23/2025.

Review of available temporary service plan (TSP) records for R8 as of 02/09/2026 showed no TSPs for the nine falls documented.

Resident 1 (R1)

Record review of R1's NSA, dated 02/02/2026, documented R1 moved into the facility on [redacted]/2025 and had a medical diagnosis of [redacted]. R1 was to get a shower one to two times weekly. There was no specific preference days or approximate times listed. The NSA indicated R1 smoked safely. The NSA did not indicate details that surrounded R1 smoking which included how R1 obtained cigarettes, where R1's cigarettes and lighter were stored, if R1 smoked independently or needed assistance, and where R1 was supposed to smoke. The medication responsibilities section documented R1 received over the counter medications, the facility was responsible to purchase and store R1's medication. The NSA did not include that Collateral Contact 3 (CC3), R1's Power of Attorney, provided the facility with R1's medications and there was not an alternate plan listed if CC3 could not provide R1's

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medication.

Record review of the facility's document titled "Lodge 1 Shower Schedule," undated, documented R1 received their showers on day shift on Wednesday's and Sunday's.

On 02/04/2026 at 1:10 PM, CC3 stated to their knowledge the facility staff were present when R1 showered in case they fell. CC3 stated they were informed that the facility maintained a shower log and told R1 when it was time to shower. CC3 stated R1 smoked and the facility staff member who also smoked periodically took R1 to smoke when they had availability.

On 02/02/2026 at 1:35 PM, R1 asked Staff D, Caregiver, for assistance with smoking. Staff D stated they were unable to do so and walked away. At 1:50 PM, R1 sat in the community room and stated they had not smoked yet because the facility staff were busy and they would ask again later. At 1:52 PM, Staff E, Activity was observed to go into the medication room, they returned and stated they volunteered to take R1 outside to smoke. Staff E stated taking residents out to smoke was not in their normal job description, but the other facility staff were busy. Staff C, Resident Care Coordinator, exited from the medication room and stated that R1 asked Staff D twice to take them to smoke. Staff C stated Staff D was underage and did not assist in taking residents to smoke and they were on the phone scheduling a doctor's appointment so R1 needed to wait. Staff L, Medication Technician, had arrived and was present and stated they would take R1 to smoke while they waited for their start of day report.

On 02/03/2023 at 5:05 PM, Staff C stated R1's cigarettes and lighter were kept in the medication cart. Staff C stated since Staff D was not legally allowed to smoke, they did not help residents smoke. Staff C stated the medication technicians or anyone who was older than 21 years old could help the smoking residents. Staff C stated R1 did not have a schedule as to when they smoked. Staff C stated when R1 smoked when they requested to and when the facility staff had time. Staff C stated the facility did not keep records of when R1 smoked.

R6

Record review of Resident 6's (R6) NSA, dated 01/23/2026, documented R6 moved into the facility on [redacted]/2024 with diagnoses including [redacted]. R6 was to get total assistance with showers one to two times weekly. There were no specific preference days or approximate times listed. R6 was independent with mobility and did not require an assisted device. The facility staff would monitor for changes and provide verbal cues if they arose. The NSA did not include that R6 used a four-wheeled walker. The toileting section did not indicate that R6 used a handheld urinal (a lightweight portable device that collected urine). The NSA indicated that R6 was not on home health services.

Record review of R6's assessment, dated 12/02/2026, showed that R6 used a walker.

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Record review of R6's document titled, "Progress Notes," dated 01/08/2026, documented physical therapy notified the facility that R6 now had a walker and the facility staff needed to remind R6 to use it.

On 02/02/2026 at 2:40 PM, observation of R6's bathroom shelf had two handheld urinals. The two handheld urinals were observed on 02/03/2026 at 12:52 PM, 02/04/2026 at 12:29 PM and on 02/05/2026 at 10:08 AM.

On 02/03/2026 at 1:31 PM, R6 had been observed to work with a home health representative and during their session R6 used a four wheeled walker. At 2:10 PM, R6 was observed to ambulate in the hallway independently.

On 02/04/2026 at 9:15 AM, Collateral Contact 6 (CC6), R6's Power of Attorney, stated R6 was currently on home health services. R6 stated R6 had issues with their mood but their medication helped them.

On 02/04/2026 at 12:32 PM, Staff G, stated R6 worked with a home health representative who helped R6 use their four wheeled walker. R6 four wheeled walker was observed in their room while R6 was elsewhere in the facility.

On 02/04/2026 at 4:52 PM, Staff C stated R6 was on home health services, and they used a walker when they worked with the physical therapist. Staff C stated the facility staff were supposed to encourage R6 to have their walker and keep the walker in their line of sight.

On 02/05/2026 at 12:13 PM, R6 had been observed to work with a home health representative and during their session R6 used a four wheeled walker.

On 02/04/2026 at 1:50 PM, review of the facility TSP binder showed R6 did not have any TSP addendum's to review.

Record review of the facility's document titled, "Resident Incident Log," dated 12/03/2025 through 01/31/2026, documented R6 had a fall on 12/07/2025 and their NSA was updated. R6 had a fall on 12/15/2025 and their NSA was updated. R6 had an injury of unknown origin on 12/18/2025 and their NSA was updated. On 01/21/2026 R6 had an "other" incident and their NSA was updated.

On 02/05/2026 at 8:16 AM, all R6's TSPs implemented were requested to review. As of 02/09/2026 there were no TSPs provided for the four incidents documented.

This document was prepared by Residential Care Services for the Locator website.

Resident 3 (R3)

Record review of R3's NSA dated 12/11/2025, documented R3 moved into the facility on [redacted]/2025 and had a medical diagnosis of [redacted]. R3 was to get a shower one to two times weekly. There was no specific preference days or approximate times listed. The medication section documented Collateral Contact 1 (CC1), R3's Power of Attorney was the person responsible to purchase all R3's medications and there was not an alternate plan listed if CC1 could not provide R3's medication.

Record review of the facility's document titled, "Lodge 1 Shower Schedule," undated, documented R3 received their showers on day shift on Monday's and Thursday's.

On 02/10/2026 at 4:00 PM, Collateral Contact 1 (CC1), R3's Power of Attorney s stated the facility was responsible to inform them when R3 needed more medication and they brought it to the facility.

On 02/13/2026 at 10:01 AM, Staff G, stated that R3 did not have a family assistance with medication plan they could provide to review.

On 02/02/2026 at 8:31 AM, Staff D, Caregiver, stated they tried to review residents care plans because there were changes often. Staff D stated the care plans were in hard charts in Lodge one and Lodge two medication rooms.

On 02/02/2026 at 8:55 AM, Staff M, Medication Technician, stated care plans were in hard charts in Lodge one and Lodge two medication rooms. Staff M stated Staff C, Staff G and other facility medication technicians notified them if a resident's care plan had been updated.

On 02/03/2026 at 2:05 PM, Staff U, Caregiver, stated they started working for the facility on 01/27/2026. Staff U stated the resident care plans were in the medication room. Staff U stated they had not been given time or had any time to read any of the residents' care plans yet.

On 02/04/2026 at 3:04 PM, Staff C stated new facility staff members were supposed to read resident care plans before they started on the floor. At 4:52 PM, Staff C stated Staff G was the only person in the facility who was responsible for updating resident care plans.

On 02/04/2026 at 4:49 PM, Staff K, Medication Technician, stated they started working for the facility on 01/27/2026. Staff K stated they had not had the time to read any of the residents' care plans yet.

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On 02/05/2026 at 12:33 PM, Staff G, stated they were the person responsible to complete resident's care plans and initiate the TSP's. Staff G stated they tried to complete a TSP one to two days after they were made aware an incident took place. Staff G stated they did not create a TSP after every incident that occurred. Staff G stated TSP's were in Lodge one and Lodge two medication rooms. Staff G stated incidents happened all the time and the facility staff were expected to review the TSP binder daily.

This is a recurring deficiency previously cited on 04/27/2023 for subsection (1)(a)(iii).

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 5/18/2026 .

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

Jodi M Stephens
Administrator (or Representative)

4/7/2026
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide the agreed upon care, as noted in the negotiated service agreement (NSA), for 5 of 7 residents (Resident 9, 4, 3, 6 and 5). This failure impacted the residents' quality of life by not having their care needs provided.

Findings included...

Record review of the facilities policy titled "Negotiated Service Agreement," dated 02/15/2024, documented the facility would provide care as agreed upon.

Resident 9 (R9)

This document was prepared by Residential Care Services for the Locator website.

On 02/05/2026 at 12:33 PM, Staff G, stated they were the person responsible to complete resident's care plans and initiate the TSP's. Staff G stated they tried to complete a TSP one to two days after they were made aware an incident took place. Staff G stated they did not create a TSP after every incident that occurred. Staff G stated TSP's were in Lodge one and Lodge two medication rooms. Staff G stated incidents happened all the time and the facility staff were expected to review the TSP binder daily.

This is a recurring deficiency previously cited on 04/27/2023 for subsection (1)(a)(iii).

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

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide the agreed upon care, as noted in the negotiated service agreement (NSA), for 5 of 7 residents (Resident 9, 4, 3, 6 and 5). This failure impacted the residents' quality of life by not having their care needs provided.

Findings included…

Record review of the facilities policy titled "Negotiated Service Agreement," dated 02/15/2024, documented the facility would provide care as agreed upon.

Resident 9 (R9)

This document was prepared by Residential Care Services for the Locator website.

Record review of R9's NSA, dated 12/06/2025, showed that R9 required extensive one-person assistance for showers one to two times a week. R9 has moderate cognitive impairment that required staff redirection and reminding them to complete tasks.

<Showers>

Record review of the facility's document titled "Shower Schedule," undated, documented R9 was to have a shower every Monday and Thursday on evening shift.

An observation on 02/04/2026 at 11:51 AM, in Lodge 2, showed R9 walking with curly hair that was uncombed, dry, tangled, greasy at the roots, with white flaky particles present.

On 02/04/2026 at 12:45 PM, Staff M, Medication Technician, stated they were unsure when R9 last had a shower and that the shower sheets had been removed from the shower binder.

An observation on 02/05/2026 at 9:42 AM showed R9 sitting at the dining room table with curly hair that was uncombed, dry, tangled, greasy at the roots, with white flaky particles present.

On 02/05/2026 at 9:48 AM, Staff M stated R9 required full staff assistance from staff to ensure they received showers, changed clothes, and toileted. Staff M stated R9 was not aware or could not make decisions when they needed to be showered or changed.

Record review of the R9's documented showers, dated 12/01/2025 through 02/05/2026, showed R9 had showers on 01/08/2026 and 02/05/2026.

Resident 4 (R4)

Record review of R4's NSA, dated 01/25/2026, documented they moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted]. R4 required extensive assistance with showers one to two times a week.

<Showers>

Record review of the facility's shower schedule, undated, documented R4 was to have a shower every Monday and Thursday on evening shift.

This document was prepared by Residential Care Services for the Locator website.

On 02/03/2026 at 12:55 PM, R4 stated they were to get two showers a week and prefered them on evening shift. R4 stated they take a shower anytime they are offered as they never knew when they would get another shower offered. R4 stated they had psoriasis (skin condition when cells grow too fast causing itchy and painful patches that can increase under stress) and a red rash under their abdomen and breasts. R4 stated they were to get a shower on 02/02/2026 but did not get it as the staff were busy. R4 stated that staff did not remind them of their scheduled shower days and that they were expected to remember on their own or they would not receive a shower.

On 02/03/2026 at 2:46 PM, Staff A, Executive Director, stated that on 01/20/2026 the facility implemented a new shower sheet for caregivers to use as the facility was unable to find any past residents shower sheets. Staff A stated they would provide showers sheets for all residents requested that included R4. Staff A stated the caregivers were to use a shower sheet and document if the resident took or refused the shower. If a resident refused a shower, the next shift caregivers would offer the shower and continue to offer each shift until a shower was provided.

On 02/04/2026 at 3:18 PM, R4 stated they did not receive a shower on 02/02/2026 or 02/03/2026.

On 02/05/2026 at 12:33 PM, Staff G, Health Services Director, stated staff document all showers on the facility's shower sheets and caregivers would document if a resident refused or received a shower.

Record review of the available shower records as of 02/09/2026 showed no documentation that R4 received or refused showers.

Resident 3 (R3)

Record review of R3's NSA, dated 12/11/2025, documented R3 moved into the facility on [redacted]/2025 and had a medical diagnosis of [redacted].

<Showers>

Record review of R3's NSA, dated 12/11/2025, showed that R3 required extensive assistance with bathing one to two times a week.

Record review of the facility's document titled "Lodge 1 Shower Schedule," undated, documented R3 received every Monday and Thursday on day shift.

This document was prepared by Residential Care Services for the Locator website.

Record review of R3's document titled "Shower Skin Assessment Checks," dated 12/01/2025, documented R3 became combative during a shower, and that staff completed a bed bath for R3. The reviewed by section was blank.

Record review of R3's document titled "Shower Skin Assessment Checks," dated 12/29/2025, documented R3 received a shower. The reviewed by section was blank.

Record review of available shower records for R3, dated 12/01/2025 – 12/31/2025, documented two showers provided.

Record review of available shower records for R3, dated 01/01/2026 – 01/31/2026, showed no documentation showers were provided.

<Bed Making>

Record review of R3's NSA, dated 12/11/2025, showed that R3 needed total assistance with housekeeping tasks and facility staff provided daily bed making.

An observation on 02/02/2026 at 2:33 PM, showed R3's bed was unmade.

An observation on 02/04/2026 at 12:06 PM, showed R3's bed was unmade.

<Meals>

Record review of R3's NSA, dated 12/11/2025, showed that R3 was on a regular diet and required staff to cut up food into bite sized pieces.

Record review of the facility's document titled "Lodge One Daily Meal Sheet," dated 02/04/2026, documented R3 was on a regular diet and needed small portions. The document did not indicate that R3 required staff to cut up food into bite sized pieces.

An observation on 02/04/2026 at 11:50 AM, in the dining room, showed R3 sitting at a table with a dinner plate containing a turkey patty and slice of toast. R3's hands shook holding the fork while cutting the turkey patty.

02/04/2026 at 11:50 AM, Staff H, Caregiver, stated that R3, for lunch, had an open face turkey burger with cranberry sauce and Texas toast. At 12:00 PM, Staff H stated there were daily meal sheets that explained residents ordered diets and any accommodations, if needed, that staff referenced daily. Staff H stated the meal sheet

This document was prepared by Residential Care Services for the Locator website.

documented R3 required small portions.

02/04/2026 at 12:00 PM, Staff N, Food Service Director, stated that they printed out the daily meal sheets every day and were responsible to update the sheets when updates were received from facility administrators.

On 02/04/2026 at 5:00 PM, Staff C stated R3 had a regular diet, did not mention any other accommodations related to R3's diet.

An observation on 02/05/2026 at 11:41 AM, in the dining room, showed R3 seated for lunch. Observation of R3's lunch plate showed a whole slice of turkey, carrots and a roll, being plated by staff, that was uncut.

On 02/05/2026 at 11:41 AM, Staff Y, Cook, stated R3 would be served turkey roast, steamed rice, carrots, and a roll.

An observation on 02/05/2026 at 12:13 PM, in the dining room, showed R3 seated for lunch with the roll, untouched, on their plate and uncut.

On 02/05/2026 at 12:14 PM, Staff N stated it was preference when residents requested their food cut and they would only cut the meat as it was more difficult to cut.

On 02/05/2026 at 2:50 PM, Staff G, Health Services Director, stated they communicated changes in resident's diets when they had the morning meeting with Staff N. Staff G stated when a new resident admitted into the facility, they emailed Staff N the residents dietary communication form to review.

On 02/10/2026 at 4:00 PM, Collateral Contact 1 (CC1), R3's Power of Attorney, stated R3 needed assistance to cut their food when it was a firmer substance.

Resident 6 (R6)

Record review R6's NSA, dated 01/23/2026, documented R6 moved into the facility on [redacted]/2024 and had a diagnosis of [redacted]. R6 needed total assistance with bathing one to two times a week. R6 required extensive assistance with dressing as the caregiver would need to select appropriate clothing, ensure they were clean, dress and undress R6. R6 was independent with mobility and did not require an assisted device. R6 needed max assist with activities of daily living such as needing a one to two person assist with transfers, and needed assistance with turning, sitting up, laying down, and staff had to physically turn the resident every two hours. R6 needed

This document was prepared by Residential Care Services for the Locator website.

total assistance to complete housekeeping tasks and the facility staff provided daily bed making.

Record review of R6's assessment, dated 12/02/2026, documented R6 needed one-person physical assistance with bathing. R6 needed extensive one-person physical assistance with dressing. R6 used a walker. Staff were to make R6's bed regularly.

Record review of R6's document titled "Progress Notes," dated 01/08/2026, documented physical therapy notified the facility that R6 now had a walker and facility staff needed to remind R6 to use it.

An observation on 02/02/2026 at 2:40 PM, in R6's unlocked apartment , showed Resident 12 (R12) laying in R6's bed. Staff H, Caregiver, confirmed R12 was inside of R6's bed and stated that it was common for R6 to wander into other resident rooms and sleep in their bed.

An observation on 02/03/2026 at 12:52 PM, in R6's unlocked apartment, showed R12 rummage inside R6's nightstand drawer. R6's bed was unmade.

An observation on 02/03/2026 at 12:56 PM, in the common area, showed that R6 was sitting at a table, wearing a grey sweater with food particles on it, had some jagged fingernails, a dark brown substance underneath the nails and one nail was bent. No walker observed in R6's vicinity.

An observation on 02/03/2026 at 1:31 PM, while working with a home health representative, showed R6 working on using a four wheeled walker.

An observation on 2:10 PM showed R6 was walking, in the hallway, without a four wheeled walker.

On 02/03/2026 at 2:46 PM, Staff A stated they could not provide any of R6's shower sheets to review.

An observation on 02/04/2026 at 12:26 PM, in the sunroom, showed R6 sitting down and no four wheeled walker in the vicinity.

An observation on 02/04/2026 at 12:29 PM, showed R6's bed did not have any bedding and the mattress was exposed.

On 02/04/2026 at 12:32 PM, Staff G, stated R6 worked with a home health representative who helped R6 use their four wheeled walker.

This document was prepared by Residential Care Services for the Locator website.

An observation on 02/04/2026 at 12:32 PM, showed R6's four wheeled walker was in their room, R6 was not in their room.

An observation on 02/04/2026 at 3:41 PM, showed R6, in the hallway, ambulating without a four wheeled walker.

On 02/04/2026 at 4:52 PM, Staff C, Resident Care Coordinator, stated R6 was on home health services, and used a walker when they worked with the physical therapist. Staff C stated the facility staff were supposed to encourage R6 to use the walker and keep the walker in R6's line of sight.

An observation on 02/05/2026 at 12:13 PM showed R6 working with a home health representative to use the four wheeled walker.

Resident 5 (R5)

Record review of R5's NSA, dated 11/03/2025, documented R5 moved into the facility on [redacted]/2024 and had a diagnosis of [redacted]. R5 ambulated independently but required daily prompts and cues to use their four wheeled walker with a seat. R5 required moderate one person assistance with bathing one to two times a week. R5 received a general diabetic diet and their food was to be cut up into small bite sized pieces. R5 needed total assistance to complete housekeeping tasks and the facility staff provided daily bed making.

Record review of R5's assessment, dated 11/18/2025, documented R5 needed one-person physical assistance with bathing, R5 needed to be cued to bath, provide assistance at R5's request, and help transfer R5 in and out of the shower. The housework caregiver instructions documented R5's bed should be made regularly.

Record review of the facility's document titled "Lodge One Daily Meal Sheet," dated 02/04/2026, documented R5 had a diabetic diet with small portions.

An observation on 02/03/2026 at 1:04 PM, in the common area, showed R5 sitting at a table and their four wheeled walker was not in the vicinity.

An observation on 02/03/2026 at 1:04 PM, inside R5's apartment, showed an unmade bed and a four wheeled walker next to the closet with clothes draped over it.

On 02/03/2026 at 1:16 PM, Staff Q, Caregiver, stated sometimes they helped R5 shower

This document was prepared by Residential Care Services for the Locator website.

and sometimes R5 showered independently.

On 02/03/2026 at 2:46 PM Staff A stated they could not provide any of R5's shower sheets for review.

An observation on 02/04/2026 at 11:52 AM, in the dining room, showed R5 sitting at a table eating. Observed R5's plate with the following uncut food: tater tots, turkey patty and toasted bread. Observed R5 having difficulties cutting the food on their plate and then picked the entire turkey patty up with a fork and took bites from the patty.

On 02/04/2026 at 5:00 PM, Staff C stated R5 had a regular diet, did not mention any other accommodations related to R5's diet.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 5/18/2026.

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

Jodi M. Stephens — Administrator (or Representative)

4/17/26 — Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;

(ii) Indicate the date, day of week, month and year;

(iii) Include all food and snacks served that contribute to nutritional requirements;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure menus were posted in resident accessible areas for 2 of 2 Lodges (Lodge 1 and 2) reviewed. This failure placed all residents at risk of a diminished quality of life.

This document was prepared by Residential Care Services for the Locator website.

and sometimes R5 showered independently.

On 02/03/2026 at 2:46 PM Staff A stated they could not provide any of R5's shower sheets for review.

An observation on 02/04/2026 at 11:52 AM, in the dining room, showed R5 sitting at a table eating. Observed R5's plate with the following uncut food: tater tots, turkey patty and toasted bread. Observed R5 having difficulties cutting the food on their plate and then picked the entire turkey patty up with a fork and took bites from the patty.

On 02/04/2026 at 5:00 PM, Staff C stated R5 had a regular diet, did not mention any other accommodations related to R5's diet.

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-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;

(ii) Indicate the date, day of week, month and year;

(iii) Include all food and snacks served that contribute to nutritional requirements;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure menus were posted in resident accessible areas for 2 of 2 Lodges (Lodge 1 and 2) reviewed. This failure placed all residents at risk of a diminished quality of life.

This document was prepared by Residential Care Services for the Locator website.

Findings included…

On 02/02/2026 at 9:47 AM, Staff N, Food Services Director, stated the menu would be posted up on the wall by the window to the kitchen and acknowledged that there was no weekly menu posted in Lodge 1. Staff A, Executive Director, acknowledged the weekly menu was not posted in Lodge 1.

On 02/02/2026 at 10:02 AM, observation in Lodge 2 showed the menu posted on the wall was labeled, “Week 1.” There were no dates listed on the menu. The menu documented lunch was cranberry pork loin, scalloped potatoes, green beans with the alternative meal being corned beef, baked potatoes with sour cream and broccoli. At 12:01 PM, Staff N served baked ham slices, sweet potato wedges, and mixed vegetables with the alternate option of cottage pie with a roll. At 12:30 PM Staff N acknowledged that there was no date on the menu and said they were using week 2 menus.

On 02/04/2026 at 11:56 AM, observation in Lodge 1 showed no weekly menu posted to review.

On 02/04/2026 3:41 PM, observation in Lodge 2 showed the weekly menu posted on the wall was week 1. The menu showed dinner was potatoes and leek soup, turkey sandwich on wheat with an alternative meal of grilled ham slices, sweet potatoes, apple casserole and green vegetables. On the whiteboard the meal written for dinner was parmesan tilapia, brown rice, vegetables with an alternative meal of apple pork chop, mashed potatoes and vegetables.

On 02/04/2026 at 3:41 PM, Resident 19 expressed a complaint that the daily menu written on the whiteboard was not always accurate to what was served.

On 02/05/2026 at 9:47 AM, observation in Lodge 2 showed week 1 menu still posted on the wall for the residents to review.

On 02/05/2026 at 10:16 AM, observation in Lodge 1 showed no weekly menu posted to review.

This document was prepared by Residential Care Services for the Locator website.

Plan/Attestation Statement

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Jodi M. Stephens — Administrator (or Representative)

4/17/26 — Date

WAC 388-78A-2070 Timing of preadmission assessment.

(1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.

(2) The assisted living facility must ensure the preadmission assessment is completed within five calendar days of the resident moving into the assisted living facility when the resident moves in under emergency conditions.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete 2 of 4 sampled residents' (Resident 2 and 4) pre-admission assessment prior to the residents move in. This failure placed both residents at risk for having unmet care needs.

Findings included...

Record review of the facility's policy titled, "Negotiated Service Agreement (NSA)", dated 02/15/2024, documented the facility provided care as agreed upon by the community and resident or resident's authorized representative in the NSA. The procedure included a qualified assessor completing a pre-admission assessment for each resident admitted to the community.

Resident 2 (R2)

Record review of R2's undated Face Sheet documented the facility admitted R2 on [redacted]/2025.

Record review of R2's document titled, "Washington Health and Service Evaluation Results and Service Plan," dated [redacted]/2025, showed it was R2's pre-move in

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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-2070 Timing of preadmission assessment.

(1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.

(2) The assisted living facility must ensure the preadmission assessment is completed within five calendar days of the resident moving into the assisted living facility when the resident moves in under emergency conditions.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete 2 of 4 sampled residents' (Resident 2 and 4) pre-admission assessment prior to the residents move in. This failure placed both residents at risk for having unmet care needs.

Findings included…

Record review of the facility's policy titled, "Negotiated Service Agreement (NSA)", dated 02/15/2024, documented the facility provided care as agreed upon by the community and resident or resident's authorized representative in the NSA. The procedure included a qualified assessor completing a pre-admission assessment for each resident admitted to the community.

Resident 2 (R2)

Record review of R2's undated Face Sheet documented the facility admitted R2 on [redacted]/2025.

Record review of R2's document titled, "Washington Health and Service Evaluation Results and Service Plan," dated [redacted]/2025, showed it was R2's pre-move in

This document was prepared by Residential Care Services for the Locator website.

evaluation.

Resident 4 (R4)

Record review of R4's undated Face Sheet documented the facility admitted R4 on [redacted]/2025.

Record review of R4's document titled, "Washington Health and Service Evaluation Results and Service Plan," dated [redacted]/2025, showed it was R4's pre-move in evaluation.

On 02/05/2026 at 12:33 PM, Staff G, Health Services Director, stated that they would be notified of all potential residents and would complete the assessment before the residents were admitted to the facility.

On 02/05/2026 at 1:24 PM, Staff A, Executive Director, stated that preadmission assessments were completed before a new resident was admitted to the facility.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 5/18/2026.

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

Jodi M. Stephens — Administrator (or Representative)

4/7/26 — Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff received all required Tuberculosis (infectious bacterial disease of the lungs) testing within the

This document was prepared by Residential Care Services for the Locator website.

evaluation.

Resident 4 (R4)

Record review of R4's undated Face Sheet documented the facility admitted R4 on [redacted]/2025.

Record review of R4's document titled, "Washington Health and Service Evaluation Results and Service Plan," dated [redacted]/2025, showed it was R4's pre-move in evaluation.

On 02/05/2026 at 12:33 PM, Staff G, Health Services Director, stated that they would be notified of all potential residents and would complete the assessment before the residents were admitted to the facility.

On 02/05/2026 at 1:24 PM, Staff A, Executive Director, stated that preadmission assessments were completed before a new resident was admitted to the facility.

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-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff received all required Tuberculosis (infectious bacterial disease of the lungs) testing within the

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required time frames for 4 of 5 sampled Staff (Staff A, B, C and U). This failure resulted in the facility failing to test staff for Tuberculosis (TB) and placed all residents, staff and visitors at risk for exposure to highly communicable disease.

Findings included…

Record review of the facility's undated policy titled, "Tuberculosis Screening and Testing for Staff," documented the facility was to ensure that all staff were screened for TB within three days of hire. If a staff member required TB testing, they either completed a TB skin test or blood test based upon the screening results. A two-step TB test included the first test within three days of hire and the second test to be administered one to three weeks after the first test was administered.

Staff A

Record review of facility's undated list of employees documented that Staff A, Executive Director's, date of hire was 12/16/2024.

Record review of Staff A's personnel records showed a TB questionnaire and testing consent form, dated 07/28/2025. The form documented that all employees must complete the questionnaire and testing consent form upon hire and prior the employee receiving the TB skin test. The questionnaire documented that Staff A consented to be tested and given their first TB skin test on 07/28/2025. There was no documentation in the records that showed Staff A completed any TB testing.

Staff B

Record review of facility's undated list of employees documented that Staff B, Caregiver's, date of hire was 08/26/2024.

Record review of Staff B's personnel records showed an undated TB questionnaire and testing consent form. The form documented all employees must complete the questionnaire and testing consent form upon hire and prior the employee receiving the TB skin test. The questionnaire documented that Staff B consented to be tested without the document being dated. Staff B's first TB skin test was administered on 08/20/2025.

Staff C

Record review of facility's undated list of employees documented that Staff C, Resident Care Coordinator's, date of hire was 12/09/2024.

This document was prepared by Residential Care Services for the Locator website.

Record review of Staff C's personnel records showed an undated TB questionnaire and testing consent form. The form documented all employees must complete the questionnaire and testing consent form upon hire and prior the employee receiving the TB skin test and must have a two-step TB skin test upon hire. The questionnaire documented that Staff C consented to be tested without the document being dated. Staff C's first TB skin test was administered on 01/20/2026. There was no second step completed. No documentation that showed Staff C had a history of prior TB skin test in last 12 months.

Staff U

Record review of facility's undated list of employees documented Staff U, Caregiver's, date of hire was 01/27/2026.

On 02/03/2026 at 2.05 PM, Staff U stated that they had not completed their first step for their TB test. Staff U stated that they were unsure of when their TB test was scheduled.

On 02/03/2026 at 4:50 PM, Staff A stated that Staff U did not complete their first step to their TB test completed within three days of hire.

On 02/03/2026 at 4:23 PM, Staff T, Business Office, stated that on the date of hire orientation, new employees received their first TB skin test and then read within three days. Staff T stated that 14 to 21 days later, staff received their second TB skin test. Staff T stated that all employees' TB skin tests were administered by Staff G, Health Services Director.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 5/18/2026.

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

Jodi McStephens — Administrator (or Representative)

4/17/26 — Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

This document was prepared by Residential Care Services for the Locator website.

Record review of Staff C's personnel records showed an undated TB questionnaire and testing consent form. The form documented all employees must complete the questionnaire and testing consent form upon hire and prior the employee receiving the TB skin test and must have a two-step TB skin test upon hire. The questionnaire documented that Staff C consented to be tested without the document being dated. Staff C's first TB skin test was administered on 01/20/2026. There was no second step completed. No documentation that showed Staff C had a history of prior TB skin test in last 12 months.

Staff U

Record review of facility's undated list of employees documented Staff U, Caregiver's, date of hire was 01/27/2026.

On 02/03/2026 at 2:05 PM, Staff U stated that they had not completed their first step for their TB test. Staff U stated that they were unsure of when their TB test was scheduled.

On 02/03/2026 at 4:50 PM, Staff A stated that Staff U did not complete their first step to their TB test completed within three days of hire.

On 02/03/2026 at 4:23 PM, Staff T, Business Office, stated that on the date of hire orientation, new employees received their first TB skin test and then read within three days. Staff T stated that 14 to 21 days later, staff received their second TB skin test. Staff T stated that all employees' TB skin tests were administered by Staff G, Health Services Director.

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-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

This document was prepared by Residential Care Services for the Locator website.

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document actions and findings for any accident or incident jeopardizing residents' health for 1 of 5 residents (Resident 8) documented to have an incident. This failure resulted in the facility being unable to determine the circumstances of the event, institute, and document appropriate measures to prevent similar situations, and protect the resident during the course of the investigation.

Findings included…

Record review of the facility's policy titled "Accidents, Incidents and Unusual Occurrences," dated 02/15/2024, documented all accidents and or incidents would be responded to, investigated, and documented in resident's health record with the action taken. The incident report and investigation form along with any additional investigation forms utilized would be kept in the community incidents binder.

Record review of the facility resident records titled "Resident Incident Log," dated 07/01/2025 through 08/31/2025, documented R8 had a fall on 07/29/2025 at 3:15 PM, 08/01/2025 at 3:30 PM and 6:00 PM, 08/02/2025 at 4:15 PM, 08/03/2025 at 12:30 AM, 08/04/2025 at 1:30 PM, 08/07/2025 at 10:55 PM, 08/14/2025 at 6:45 AM and 08/23/2025 at 11:30 AM. The facility was unable to provide R8's temporary service plans (TSP) for the falls.

Record review of R8's progress note, dated 08/08/2025 at 5:16 AM, documented they were found on the floor on the right wheel of their wheelchair by the medication technician complaining of hip pain.

On 02/05/2026 at 8:16 AM, all R8's incident reports and investigations were requested during stay at the facility were requested.

Record review of an email sent to the Department on 02/06/2026 at 4:14 PM, documented that the facility was unable to provide the requested incident reports and investigations for R8. The facility would still work on getting the documents. As of 02/20/2026 at 5:00 PM, the facility was unable to provide any incident reports or investigations for R8 for review.

This document was prepared by Residential Care Services for the Locator website.

On 02/11/2026 at 4:21 PM, Staff G, Health Service Director, stated the facility's electronic system would not allow them to open the incident reports and investigations for R8 to provide a copy and unable to send them for review.

This is a recurring deficiency previously cited on 04/27/2023 under subsections (1)(2)(3)(4).

Plan/Attestation Statement

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Jodi Mc Stephens — Administrator (or Representative)

4/17/26 — Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 2 sampled staff (Staff F and V) had completed their annual continued education units (CEU). The facility failed to ensure 1 of 6 sampled staff (Staff D) had their food worker's card. The facility failed to ensure 2 of 5 sampled staff (Staff I and Q) knew the process on mandated reporting. The facility failed to ensure 2 of 2 sampled new staff (Staff U and K) had been trained on resident care plan and temporary service plans to perform their job responsibilities. These failures placed all residents at risk of being improperly cared for by untrained staff.

Findings included...

Record review of the facility's document titled, "New Employee Orientation," undated, documented the administrative orientation had a topic section on abuse reporting. The resident care orientation had a topic on characteristics and needs of the residents. The

This document was prepared by Residential Care Services for the Locator website.

On 02/11/2026 at 4:21 PM, Staff G, Health Service Director, stated the facility's electronic system would not allow them to open the incident reports and investigations for R8 to provide a copy and unable to send them for review.

This is a recurring deficiency previously cited on 04/27/2023 under subsections (1)(2)(3)(4).

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-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 2 of 2 sampled staff (Staff F and V) had completed their annual continued education units (CEU). The facility failed to ensure 1 of 6 sampled staff (Staff D) had their food worker's card. The facility failed to ensure 2 of 5 sampled staff (Staff I and Q) knew the process on mandated reporting. The facility failed to ensure 2 of 2 sampled new staff (Staff U and K) had been trained on resident care plan and temporary service plans to perform their job responsibilities. These failures placed all residents at risk of being improperly cared for by untrained staff.

Findings included…

Record review of the facility's document titled, "New Employee Orientation," undated, documented the administrative orientation had a topic section on abuse reporting. The resident care orientation had a topic on characteristics and needs of the residents. The

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position specific orientation had a topic that included food handler's permit.

CEU

Washington Administrative Code (WAC) 388-112A-0611 "(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section.(a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year:(i) A certified home care aide;(ii) A long-term care worker who is exempt from the 70-hour home care aide basic training under WAC 388-112A-0090 (1) and (2);(iii) A certified nursing assistant;(iv) A person with special education training and an endorsement granted by the Washington state office of superintendent of public instruction, as described in

Revised Code of Washington (RCW) 28A.300.010; and(v) An assisted living facility administrator or the administrator designee as provided under WAC 388-112A-0060.(b) A long-term care worker, who is a certified home care aide must comply with continuing education requirements under chapter 246-980 WAC.(c) The continuing education requirements of this section do not apply to a registered nurse, a licensed practical nurse, and an advanced registered nurse practitioner licensed under chapter 18.79 or 18.80 RCW, even if voluntarily certified as a home care aide under chapter 18.88B RCW.(d) If exempt from certification under RCW 18.88B.041, a long-term care worker must complete and provide documentation of 12 hours of continuing education within 45 calendar days of being hired by the assisted living facility or by the long-term care worker's birthday in the calendar year hired, whichever is later; and(i) Must complete 12 hours of continuing education by the long-term care worker's birthday each calendar year worked thereafter; or(ii) If the 45 calendar day time period allows the long-term care worker to complete continuing education in January or February of the following year, the credit hours earned will be applied to the calendar year in which the long-term care worker was hired.(e) If the birthday following initial certification as a home care aide or nursing assistant (NA-C) is less than a full year from the date of initial certification, no continuing education will be due for the first renewal period.(2) A long-term care worker who does not complete continuing education as required under this chapter must not provide care until the required continuing education is completed."

WAC 388-110-220 "Enhanced adult residential care service standards… (3) In an assisted living facility with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must… (d) Ensure that each staff who works directly with residents has at least six hours of continuing education per year related to dementia, including Alzheimer's disease. This six hours of continuing education may be part of the ten hours of continuing education required by WAC 388-112-0205."

Staff F, Medication Technician

Record review of the facility's untitled and undated staff list, documented Staff F was hired on 06/01/2021 and their birthday was June 17th.

On 02/03/2026 at 9:01 AM, the Department requested Staff F's CEU's dated 06/17/2024 through 06/17/2025 for review.

Record review of the CEU's provided for Staff F, documented Staff F had zero hours completed during the dates of 06/17/2024 through 06/17/2025 provided.

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Staff V, Caregiver

Record review of the facility's untitled and undated staff list, documented Staff V was hired on 02/28/2024 and their birthday was March 21st.

On 02/03/2026 at 9:01 AM, the Department requested Staff V's CEU's dated 03/21/2024 through 03/21/2025 for review.

Record review of the CEU's provided for Staff V, documented Staff V had 11.75 hours completed during the dates of 03/21/2024 through 03/21/2025 provided.

On 02/03/2026 at 4:25 PM, Staff T, Business Office, stated they were responsible to ensure the facility staff had their CEU's completed by their birthday.

On 02/03/2026 at 4:50 PM, Staff A, Executive Director, confirmed Staff F did not have any more CEU's to provide to review and Staff V did not have any more CEU's to provide to review and was short 0.25 hours.

Food Worker's Card

WAC 246-217-015 (1) "(1) All food service workers must obtain a food worker card within fourteen calendar days from the beginning of employment at a food service establishment, except as provided in subsection (4) of this section."

Staff D, Caregiver

Record review of the facility's untitled and undated staff list, documented Staff D was hired on 10/21/2025.

On 02/03/2026 at 9:01 AM, Staff D's food workers card was requested for review.

On 02/03/2026 at 12:28 PM, Staff A stated Staff D did not have a food workers card that the facility was able to provide to review.

Mandated Reporting

Record review of the facility's policy titled, "Abuse and Neglect-Resident," dated 02/15/2024, documented all staff members would be educated about abuse and neglect in the assisted living setting. During orientation and annually the facility staff would be trained on mandatory reporting. Alleged abuse would be immediately reported by the person who witnessed it to the supervisor on duty, the administrator, and the appropriate state agency.

Staff I, Housekeeping

Record review of the facility's untitled and undated staff list, documented Staff I was hired on 05/27/2025.

On 02/03/2026 at 12:08 PM, Staff I stated if they were concerned a resident was abused or neglected, they would report it to the facility medication technician and possibly Staff A. When asked if Staff I would report to anyone else, Staff I stated no that's it.

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Staff Q, Caregiver

Record review of the facility's untitled and undated staff list, documented Staff Q was hired on 08/06/2025.

On 02/02/2026 at 9:05 AM, Staff Q stated the medication technician would call the state hotline number and would report all concerns to their medication technician on shift. Staff Q was unable to provide the Department with any examples of when to call the state hotline number.

Care Plan Training

Staff U, Caregiver

Record review of the facility's untitled and undated staff list, documented Staff U was hired at the facility on 01/27/2026.

On 02/03/2026 at 2:05 PM, Staff U was observed to check into their caregiving shift. Staff U stated the resident care plans were in the medication room. Staff U stated they had not been given time or had any time to read any of the residents' care plans yet. Staff U stated they were trained for three days and then released to work independently caring for the residents in the facility.

Staff K, Medication Technician

Record review of the facility's untitled and undated staff list, documented Staff K was hired on 01/27/2026.

On 02/04/2026 at 4:49 PM, Staff K stated they had not had the time to read any of the residents' care plans yet. Staff K stated that they asked the other facility staff questions when they needed information about the residents' care needs.

On 02/04/2026 at 2:19 PM, Staff T stated in the facility orientation there was a section that covered characteristics and needs of the residents and they thought new facility
staff members reviewed all of the resident's care plans then. Staff T stated Staff C, Resident Care Coordinator and Staff G, Health Services Director, were responsible to review that section with new facility staff.

On 02/04/2026 at 3:04 PM, Staff C stated new facility staff members were supposed to read resident care plans before they started on the floor. Staff C stated there was not a designated time for when facility staff reviewed care plans and they asked the caregivers to complete it in their leisure.

On 02/05/2026 at 12:33 PM, Staff G stated new facility staff members should review the resident care plans before they started working independently with the residents. Staff G stated resident care plans were reviewed during the facility orientation. Staff G stated they verbally informed new facility staff members about the resident care plans and Staff C was the person who showed the new staff members the care plans.

Temporary Service Plans

This document was prepared by Residential Care Services for the Locator website.

On 02/04/2026 at 12.45 PM, Staff H, Medication Technician, stated all caregivers and medication technicians were to review the care plan binder and the TSP binder every day upon arriving for their shift for any new changes to residents' care. Staff H stated that they do not look at the binders as they got report from the off going medication technician of the changes to the residents.

On 02/04/2026 at 1.52 PM, Staff G stated each Lodge has a binder for the residents TSP's. Staff G stated that all caregivers and medication technicians were required to review the TSP binder every day as there were changes all the time to the resident's care and services.

On 02/04/2026 at 1:55 PM, Staff H, Caregiver, stated they were to review the TSP binder daily but typically only has time to review the binder every few days. Staff H stated they reviewed the care plan binder after a new resident was admitted to the facility or when there was a decline in a resident's condition. If Staff H were told of any changes to a resident by the medication technician, then they would review the TSP binder for the changes.

On 02/05/2026 at 12.33 PM, Staff G stated they implemented the residents TSP's when there were changes. Staff G stated they do not have the medication technicians, or the caregivers sign the residents TSP to indicate they were reviewed and tell them to review the TSP binder daily.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Memory Care At The Lodges is or will be in compliance with this law and / or regulation on (Date) 5/18/2026.

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

Jodi M. Stephens — Administrator (or Representative)

4/17/26 — Date

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(1) General characteristics:

(a) Units must have lever door hardware and option for lockable entry doors.

(i) Locking entry doors must unlock with single lever handle motion;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure 2 of 2 residents' (Resident 5 and Resident 17) apartment doors were able to be locked. This

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On 02/04/2026 at 1:52 PM, Staff G stated each Lodge has a binder for the residents TSP's. Staff G stated that all caregivers and medication technicians were required to review the TSP binder every day as there were changes all the time to the resident's care and services.

On 02/04/2026 at 1:55 PM, Staff H, Caregiver, stated they were to review the TSP binder daily but typically only has time to review the binder every few days. Staff H stated they reviewed the care plan binder after a new resident was admitted to the facility or when there was a decline in a resident's condition. If Staff H were told of any changes to a resident by the medication technician, then they would review the TSP binder for the changes.

On 02/05/2026 at 12:33 PM, Staff G stated they implemented the residents TSP's when there were changes. Staff G stated they do not have the medication technicians, or the caregivers sign the residents TSP to indicate they were reviewed and tell them to review the TSP binder daily.

Plan/Attestation Statement

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Administrator (or Representative) Date

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(a) Units must have lever door hardware and option for lockable entry doors;

(i) Locking entry doors must unlock with single lever handle motion;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure 2 of 2 residents' (Resident 5 and Resident 17) apartment doors were able to be locked. This

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failure caused Resident 5 and Resident 17 to be fearful at night and placed both at risk for a decreased quality of life.

Findings included…

On 02/03/2026 at 3:01 PM, Staff C, Resident Care Coordinator, stated that not all the resident apartment room doors were lockable.

On 02/04/2026 at 3:25 PM, observation in Lodge 1 showed five resident apartment rooms without lockable door handles.

On 02/04/2026 at 3:29 PM, observation in Lodge 2 showed seven resident apartment rooms without lockable door handles.

Resident 5 (R5)

On 02/05/2026 at 9:35 AM, Collateral Contact 2 (CC2), R5's Representative, stated that R5's apartment room did not have a lock on it. CC2 stated that they requested one on R5's behalf. CC2 stated that whenever they visited R5, they observed male residents enter R5's apartment without permission. CC2 stated that when they visited R5 mid-January, they observed a male resident enter R5's apartment. The male resident sat on the bed across from R5 and stared at R5. CC2 stated that R5 started to cry and screamed at the male resident to leave. CC2 stated that their spouse physically left the room to find a facility staff member to take the male resident out of R5's apartment. CC2 expressed frustration that male residents entered R5's apartment in the middle of the night and early morning. CC2 stated that R5 woke up terrified, cried, and stated that they could not sleep. CC2 stated that they did not think R5 felt safe living in the facility. CC2 stated that they reported this concern to Staff A, Executive Director, and Staff T, Business Office.

Resident 17 (R17)

Record review of the facility's document titled, "Maintenance Request Form," dated "1/06", showed R17 requested a lock due to male residents entering their room when they used the bathroom.

On 02/04/2026 at 3:04 PM, Staff C stated that R17 wanted a lock on their apartment door because a male resident kept entering their room. Staff C stated that on 02/03/2026, R17 moved rooms. Staff C stated that on the 11/06/2025, they completed a work order for a lockable door handle to be installed on R17's apartment door. Staff C stated that they accidentally wrote R17's previous room number on the work order.

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On 02/05/2026 at 10:12 AM, R17 stated that when they were in their previous apartment, they requested a door that locked with a key so that male residents could not enter their room without permission. R17 stated that other residents entered their room and deliberately peed on their bathroom floor and laid down in their roommate's bed. R17 stated they did not feel safe and screamed, telling the male resident to get out. R17 stated that they had a hard time sleeping at night because they did not know what was going to happen to them once they fell asleep.

On 02/05/2026 at 10:20 AM, Staff C stated that they completed another work order for R17 to get a lock and key because a male resident kept entering R17's room and urinating on their floor.

Plan/Attestation Statement

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

Jodi M. Stephens — Administrator (or Representative)

4/17/26 — Date

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;

(2) Be provided both orally and in writing in a language that the resident understands;

(3) Be provided to prospective residents, before they are admitted to the home,

(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 7 of 7 sampled

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On 02/05/2026 at 10:12 AM, R17 stated that when they were in their previous apartment, they requested a door that locked with a key so that male residents could not enter their room without permission. R17 stated that other residents entered their room and deliberately peed on their bathroom floor and laid down in their roommate's bed. R17 stated they did not feel safe and screamed, telling the male resident to get out. R17 stated that they had a hard time sleeping at night because they did not know what was going to happen to them once they fell asleep.

On 02/05/2026 at 10:20 AM, Staff C stated that they completed another work order for R17 to get a lock and key because a male resident kept entering R17's room and urinating on their floor.

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Administrator (or Representative) Date

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(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 7 of 7 sampled

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Residents (Resident 1, 2, 3, 4, 5, 6 and 7) were provided with a copy of the facility's Medicaid Policy. This failure placed all residents at risk of making uninformed decisions about placement with consideration of potential changes in their financial circumstances.

Findings included…

Record review of the facility's document titled, "Disclosure of Services Required by RCW (Revised Code of Washington) 18.20.300," dated "01/2023," documented the facility admitted [redacted] payment recipients on a case-by-case basis.

Record review of Resident 1's (R1) undated Face Sheet documented the facility admitted R1 on [redacted]/2025.

Record review of R1's Residence and Care Agreement, dated [redacted]/2025, documented there was no signed copy of the facility's Medicaid payment policy.

Record review of Resident 2's (R2) undated Face Sheet documented the facility admitted R2 on [redacted]2025.

Record review of R2's Residence and Care Agreement, dated 07/21/2025, documented there was no signed copy of the facility's Medicaid payment policy.

Record review of Resident 3's (R3) undated Face Sheet documented the facility admitted R3 on [redacted]/2025.

Record review of R3's Residence and Care Agreement, dated 08/06/2025, documented there was no signed copy of the facility's Medicaid payment policy.

On 02/10/2026 at 4:00 PM, Collateral Contact 1 (CC1), R3's Power of Attorney, stated that R3 was a private pay resident. CC1 stated that they assumed when R3 needed to go on [redacted] services, R3 could stay at the facility.

Record review of Resident 4's (R4) undated Face Sheet documented the facility admitted R4 on [redacted]/2025.

Record review of R4's Residence and Care Agreement, dated 05/22/2025, documented there was no signed copy of the facility's Medicaid payment policy.

Record review of Resident 5's (R5) undated Face Sheet documented the facility

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admitted R5 on [redacted]/2024.

Record review of R5's Residence and Care Agreement, dated 12/19/2024, documented there was no signed copy of the facility's Medicaid payment policy.

Record review of Resident 6's (R6) Face Sheet undated documented the facility admitted R6 on [redacted]/2024.

Record review of R6's Residence and Care Agreement, dated 02/18/2025, documented there was no signed copy of the facility's Medicaid payment policy.

Record review of Resident 7's (R7) undated Face Sheet documented the facility admitted R7 on [redacted]2014.

Record review of R7's Residence and Care Agreement, dated 02/18/2025, documented there was no signed copy of the facility's Medicaid payment policy.

On 02/03/2026 at 4:52 PM, Staff A, Executive Director, stated that the private pay residents' residency contract did not include the [redacted] addendum. Staff T, Business Office, stated that the [redacted] addendum did not include information about spending down or whether the facility accepted [redacted] as payment. Staff O, Director of Operations, acknowledged that all residents who were admitted to the facility, regardless of payment source, needed to be provided with a copy of the facility's Medicaid payment policy to review and sign.

This is a recurring deficiency previously cited on 04/27/2023 for subsection (6).

Plan/Attestation Statement

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

Joann M. Stephens
Administrator (or Representative)

4/17/26
Date

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admitted R5 on [redacted]/2024.

Record review of R5's Residence and Care Agreement, dated 12/19/2024, documented there was no signed copy of the facility's Medicaid payment policy.

Record review of Resident 6's (R6) Face Sheet undated documented the facility admitted R6 on [redacted]/2024.

Record review of R6's Residence and Care Agreement, dated 02/18/2025, documented there was no signed copy of the facility's Medicaid payment policy.

Record review of Resident 7's (R7) undated Face Sheet documented the facility admitted R7 on [redacted]/2014.

Record review of R7's Residence and Care Agreement, dated 02/18/2025, documented there was no signed copy of the facility's Medicaid payment policy.

On 02/03/2026 at 4:52 PM, Staff A, Executive Director, stated that the private pay residents' residency contract did not include the [redacted] addendum. Staff T, Business Office, stated that the [redacted] addendum did not include information about spending down or whether the facility accepted [redacted] as payment. Staff O, Director of Operations, acknowledged that all residents who were admitted to the facility, regardless of payment source, needed to be provided with a copy of the facility's Medicaid payment policy to review and sign.

This is a recurring deficiency previously cited on 04/27/2023 for subsection (6).

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

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