STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

06/17/2026

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

RE: Memory Care At The Lodges # 2600

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 78921 (Completion Date 06/17/2026) and 75833 (Completion Date 05/14/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/17/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

The Department staff who did the On Site verification:
Pamela Horlick, NCI RN Complaint Investigator
Rebecca Kane, Regional Administrator

If you have any questions, please contact me at (360)664-8423.

Sincerely,

Rebecca Kane

Rebecca Kane, Regional Administrator
Region 3, Unit E

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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: 219031
Compliance Determination #: 75833
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 04/14/2026 through 05/14/2026
Complainant Contact Date(s):

Allegation(s):

1. Infection control: Report of multiple residents with a skin infection.
2. Administration Personnel: Report of facility staff not assessing residents.
3. Physical Environment: Report of multiple residents with a skin infection sitting on common area furniture.

Investigation Methods:

Sample:
Total residents: 46
Resident sample size: 7
Closed records sample size: 0

Observations:
Residents
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Nursing staff
Residents
Executive Director
Health Services Director

Record Reviews:
Medical records
State reporting log
Facility policies
Progress Notes
Shower Sheets
Temporary Care Plan
Assessment
Physician Orders

Investigation Summary:

1. Infection control: Facility failed to notify the local health jurisdiction when multiple residents exhibited symptoms of an skin infection. Failed practice identified.
2. Administration Personnel: Issue addressed during the full inspection.
3. Physical Environment: Facility has a process in place to disinfect common area

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furniture. Unable to substantiate failed practice.

Conclusion / Action:

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

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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: 223011
Compliance Determination #: 75833
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 04/14/2026 through 05/14/2026
Complainant Contact Date(s):

Allegation(s):
1. Infection control: Report of multiple residents with a skin infection.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 7 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Executive Director Health Services Director
Record Reviews:	Medical records State reporting log Facility policies Progress Notes Shower Sheets Temporary Care Plan Assessment Physician Orders

Investigation Summary:
1. Infection control: Facility failed to notify the local health jurisdiction when multiple residents exhibited symptoms of an skin infection. Failed practice identified.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

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☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Rec'd 5/18/26 jmg

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License # 2600	Compliance Determination # 75833
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 1 of 8	Licensee: Greenlake Management Lacey, LLC	05/14/2026

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 04/14/2026 of:

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

This document references the following complaint number(s): 219031, 223011

The following sample was selected for review during the unannounced on-site visit: 7 of 46 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility.

Pamela Horlick, NCI RN Complaint Investigator

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

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Statement of Deficiencies	License #: 2600	Compliance Determination #75933
Plan of Correction	Memory Care At The Lodges	Completion Date
Page 2 of 8	Licensee: Greenlake Management Lacey, LLC	05/14/2026

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

05/18/2026
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.

Administrator (or Representative)

5/22/26
Date

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility (ALF) failed to report to the local health jurisdiction when the facility had a cluster of unknown skin infections affecting 7 of 7 resident (Resident 1, 2, 3, 4, 5, 6, and 7) reviewed. This failure resulted in all seven residents suffering a decreased quality of life and placed all residents at risk of contracting a communicable disease.

Findings included...

Record review of facility policy titled, "Supplemental Infection Prevention and Control Program," dated 02/15/2024, showed that the facility will be on the lookout for any infections and/or communicable diseases and notify the local health jurisdiction (LHJ) and the Department of all reportable diseases and that an outbreak investigation may be required when there is a cluster of infections above expected levels.

WAC 246-100-021 "Responsibilities and Duties-Health Care Providers" showed that every health care provider, as defined in chapter 246-100 WAC, shall: (3) Comply with requirements in WAC 246-100-206, 246-100-211, and chapter 246-101 WAC.

WAC 246-101-010 (31) "Outbreak" means the occurrence of a condition in an area over

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a given period of time in excess of the expected number of occurrences including, but not limited to, foodborne disease, waterborne disease, and health care-associated infection.

WAC 246-101-101 "Notifiable conditions-Health Care Providers and Health Care Facilities" showed Outbreaks and suspected outbreaks are immediately notifiable conditions to the LHJ (local health jurisdiction).

Review of the Department of Health (DOH) webpage titled, "Disease Outbreak Reporting," showed an outbreak is defined by the CDC [Center for Disease Control] as an occurrence of cases of disease that is more than expected, or cases clustered by time, space, or common behaviors... All outbreaks or suspected outbreaks of a disease are immediately notifiable to the local health jurisdiction in which the patients reside... Outbreaks or suspected outbreaks of a disease that occur in a health care facility or are treated by a health care provider are notifiable to the local health jurisdiction.

In an interview on 04/09/2026 at 3:24PM, Collateral Contact 3 (CC3) stated there have been residents with a rash and scratching themselves until they bleed for about a year. CC3 stated residents go back and forth between the two buildings of the ALF, sitting in different areas and it [the infection] gets passed on to other residents. CC3 stated it has been reported to the nurse, business office manager and the executive director and they do nothing about it. CC3 stated they have seen residents scratch until they bleed. CC3 stated staff are complaining of "itchiness" now.

In an interview on 04/14/2026 at 11:59 AM, Staff A, Health Services Director, stated they plan on treating everyone suspected of having scabies (a skin infestation caused by tiny mites that burrow into the top layer of skin to live and lay eggs). Staff A stated there are 15-16 suspected cases of scabies.

<Resident 1>

Record review of facility records showed that R1 was admitted to the facility on [redacted]/2024 with a diagnosis of [redacted].

In an observation and interview on 04/14/2026 at 10:04 AM, Resident 1 (R1) stated they were itchy on their arms and their back. R1 was observed to have little clusters of small red marks on both of their upper arms. R1's back had small scabs scattered around their whole back.

Record review of R1's "Skin Integrity Monitoring Form" first documented the resident had itching and a rash on 3/12/2026. Further review showed R1 continued to have a

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rash/itching to the left arm, chest and had red marks on their body on 03/18/2026, 03/22/2026 and 03/29/2026.

Record review of facility provided document titled "Temporary Service Plan," dated 03/17/2026, showed R1 had suspected scabies.

Record review of R1's progress notes did not show any documentation about a rash until 04/14/2026. On 04/16/2026 progress notes showed R1 had a rash all over their body.

Record review of an email from Staff A to the Department, dated 05/7/2026 at 12:43 PM, showed R1 was treated for scabies on 04/30/2026 and 05/06/2026.

<Resident 2>

Record review of facility records showed that Resident 2 (R2) was admitted to the facility on [redacted]/2021 with a diagnosis of [redacted].

Record review of R2's "Skin Integrity Monitoring Form" showed that on 03/22/2026 R2 had a rash/itching and "red dots and scratches on [R2's] body."

Record review of facility provided document titled, "Temporary Service Plan," dated 03/26/2026 showed R2 had suspected scabies.

In an observation and interview on 04/14/2026 at 10:29 AM, R2 stated they itch all over their body and it hurts. R2 was observed to have numerous red scabs and scratch marks on both upper arms. R2 had small red scratches and scabs on the lefts side of their back. R2 was observed to begin to scratch their chest where red small red bumps were noted. R2 stated that it is "uncomfortable."

In an observation and interview on 04/14/2026 at 1:34 PM, R2 observed to have a rash on the front of both their upper thighs and stated, "it itches."

Record review of R2's progress notes showed from 03/03/2026 through 04/13/2026 there were no progress notes indicating resident had a rash. On 04/14/2026, it was noted R2 had a rash all over their body.

Record review of an email from Staff A to the Department, dated 05/7/2026 at 12:43 PM, showed R2 was treated for scabies on 04/30/2026 and 05/06/2026.

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<Resident 3>

Record review of facility records showed that Resident 3 (R3) was admitted to the facility on [redacted]/2023 with a diagnosis of [redacted]

Record review of R3's "Skin Integrity Monitoring Form" showed on 03/12/2026 and 03/18/2026 R3 had a rash/itching with a "rash on back and arms from scratching" and "rash on arms and back and was very itchy."

Record review of facility provided document titled, "Temporary Service Plan," dated 03/14/2026 showed R3 had suspected scabies.

Record review of R3's progress notes showed the following: Between 03/12/2026 and 04/11/2026 there were several entries stating R3 was on alert for a rash on their body including their right arm, back, upper thigh area, abdomen/under breasts and neck. Resident appeared to be very itchy and continued to go up to the walls and corners to itch their back. R3 continued to be itchy and scratch throughout the day and exhibit behaviors of agitation. R3 complained about the rash and how much it itched.

In an observation on 04/14/2026 at 11:02 AM, R3 was observed to have scattered light red blotches on their upper arms.

<Resident 4>

Record review of facility records showed that Resident 4 (R4) was admitted to the facility on [redacted]2024 with a diagnosis of [redacted].

Record review of facility provided document titled, "Temporary Service Plan," dated 03/17/2026 showed R3 had suspected scabies.

Record review of R4's "Skin Integrity Monitoring Form" showed on 03/18/2026 R4 had a rash/itching.

Record review of R4's progress notes from 03/17/2026 through 04/13/2026 showed there were no notes regarding skin issues. On 04/14/2026 R4 had a rash all over their body and was complaining of itchiness, especially on their arms. R4 is on alert for suspected scabies.

In an observation and interview on 04/14/2026 at 10:23 AM, R4 was observed sitting in

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the common area in a recliner aggressively scratching their left and right arms. R4's left arm had numerous red inflamed dots that they were scratching. Observation of R4's back had numerous bright red open and scabbed wounds. R4 stated their skin itched and hurt sometimes.

Record review of an email from Staff A to the Department, dated 05/7/2026 at 12:43 PM, showed R4 was treated for scabies on 04/30/2026 and 05/06/2026.

<Resident 5>

Record review of facility records showed that Resident 5 (R5) was admitted to the facility on [redacted]/2026 with a diagnosis of [redacted]

Record review of R5's "Skin Integrity Monitoring Form" showed that on 03/08/2026, 03/25/2026, and 03/29/2026, R5 had redness on their body, a rash with itching including scratches and red dots on arms, legs and back with scratches all over their body.

Record review of R5's progress notes from 03/08/2026 through 04/14/2026 did not show any notes regarding skin condition including any scratches on their body.

In an observation on 04/14/2026 at 11:10 AM, R5 was observed to have scattered light red blotches and bumps on their upper right arm, their abdomen and upper back. R5 was observed to itch their arms as they walked out of their room.

In an interview on 04/28/2026, Staff A stated that they were not aware that R5 had been itching and had any skin issue until they were notified by the department on 04/14/2026.

Record review of an email from Staff A to the Department, dated 05/7/2026 at 12:43 PM, showed R5 was treated for scabies on 05/06/2026.

<Resident 6>

Record review of facility records showed that Resident 6 (R6) was admitted to the facility on [redacted]/2026 with a diagnosis of [redacted]

Record review of facility provided document titled, "Temporary Service Plan," dated

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03/03/2026 showed R3 had suspected scabies.

Record review of R8's "Skin Integrity Monitoring Form" showed on 03/06/2026, 03/09/2026, and 03/17/2026, documented R8 had rash/itching and was "very rashy."

In an observation on 04/14/2026 at 10:10 AM, R6 was found in another resident's room and was brought out of the room. R6 was observed to be aggressively scratching their right chest area and observed to have little red scabs on both arms and chest area.

Record review of R8's progress notes showed on 03/01/2026 and 04/14/2026 R8 had a red itchy rash on their arms and all over their body. There were no other notes regarding the rash.

Record review of an email from Staff A to the Department, dated 05/7/2026 at 12:43 PM, showed R6 was treated for suspected scabies on 04/30/2026 and 05/06/2026.

<Resident 7>

Record review of facility records showed that Resident 7 (R7) was admitted to the facility on [redacted] 2026 with a diagnosis of [redacted]

Record review of R7's progress notes from 03/02/2026 through 03/10/2026 showed that R7 had a red rash all over their body and was itching and scratching. R7 returned from the hospital on 03/16/2026 still with a red rash all over their body. On 03/22/2026 and 03/31/2026 progress notes showed that R7 continued to scratch all over.

Record review of R7's "Skin Integrity Monitoring Form" showed on 03/05/2026, 03/19/2026, 03/23/2026, and 03/26/2026 that R7 had a rash/itching all over their body including back side, legs and front side.

In an observation on 04/14/2026 at 10:15 AM, R7 was observed to have small red bumps/rash on back of both arms, wrists and hands and was actively scratching at their wrists.

In an observation on 04/14/2026 at 12:58 PM, R7 observed to have a rash over entire back including scratch marks, upper things have scattered areas of red blotches on upper thighs and buttocks. R7 was observed scratching their wrists and hands.

In an interview on 04/14/2026 at 12:58 PM, Staff B, medication technician, stated the

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scratches on R7's back are from them scratching their back and that R7's rash was worse than all the other residents.

Record review of R7's progress notes on 04/14/2026 showed that R7 had a rash all over their body and was on alert for suspected scabies.

Record review of an email from Staff A to the Department, dated 05/7/2026 at 12:43 PM, showed R7 was treated for scabies on 04/30/2026 and 05/07/2026.

In an interview on 04/15/2026 at 12:10 PM, Collateral Contact 1 (CC1), Senior Epidemiologist, stated seven people with an itchy rash is considered an outbreak and should be reported to the local health jurisdiction. CC1 stated their job is to give resources to the facility to slow down the transmission.

In an interview on 04/24/2026 at 10:38 AM, Collateral Contact 2 (CC2), Outbreak and Infection Prevention Supervisor, stated any cluster of illness that is more than a usual amount is reportable to us under outbreak and suspected outbreak. Seven cases are way too many and should have been reported to the LHJ right away.

In an interview on 04/14/2026 at 1:55 PM, Staff A stated they had not reached out to the LHJ to inform them of the outbreak.

In an interview on 04/24/2026 at 1:35PM, Staff A stated at the time of the visit from the Department on 04/14/2026 they had not reached out to the LHJ and should have. Staff stated they did not know they needed to for skin infections. Staff A stated based on the policy they provided they should have informed the LHJ after there was more than one resident with the rash. Staff A stated they should have informed the LHJ early march.

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) 5/29/26.

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

Administrator (or Representative) — Date: 5/22/26

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