STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

09/04/2024

MILL CREEK SPECIAL CARE COMMUNITY LLC
THE COTTAGES AT MILL CREEK
13200 10TH DRIVE SE
MILL CREEK, WA 98012

RE: THE COTTAGES AT MILL CREEK License # 1977

Dear Administrator:

This letter addresses Compliance Determination(s) 46321 (Completion Date 08/27/2024) and 43286 (Completion Date 07/01/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/27/2024 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-2150-1, WAC 388-78A-2260-1, WAC 388-78A-2260-2-d

The Department staff who did the on-site verification:
Cristina Gonzalez, ALF Licensor

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

Statement of Deficiencies	License #: 1977	Compliance Determination # 43286
Plan of Correction	THE COTTAGES AT MILL CREEK	Completion Date
Page 1 of 5	Licensee: MILL CREEK SPECIAL CARE COMMUNITY LLC	07/01/2024

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 06/26/2024 and 06/26/2024 of:
THE COTTAGES AT MILL CREEK
13200 10TH DRIVE SE
MILL CREEK, WA 98012

This document references the following SOD dated: 07/01/2024

The following sample was selected for review during the unannounced on-site visit: 3 of 39 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Cristina Gonzalez, ALF Licensor
Allison Nunn, Long Term Care Surveyor
Roger Harrington, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Laurie Anderson for Kim Ripley — 07/15/2024

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) 7/16/24 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;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 4 residents (Resident 1, Resident 2, and Resident 4) signed the Negotiated Service Agreement (NSA). This failure placed Resident 1, Resident 2, and Resident 4 at risk of not being aware of or agreeing to their plan of care.

Findings included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 03/19/2024, the ALF received a citation for this regulation. The ALF signed an attestation statement that the facility would have a system in place and the deficiency corrected by 05/03/2024.

Review of ALF's policy titled, "Negotiated Service Agreement," dated 10/01/2020, showed that the NSA is based on discussions with the resident/representative and information gathered by the qualified assessor and should be signed by the resident or resident representative after its completion. The policy showed that the signed NSA will be kept in the resident's record.

On 06/26/2024 at 10:53 AM, Staff A, Executive Director, stated that the signed NSAs should be in the resident's record which is kept in individually labeled binders in the nurse's office.

Resident 1

Review of Resident 1 records showed the facility admitted Resident 1 on [redacted]/2024.

Review of Resident 1's NSA, dated 11/28/2023, showed no signature by Resident 1 or Resident 1's representative.

On 06/27/2024 at 1:30 PM, Collateral Contact 1, legal representative for Resident 1, stated that they had not seen or signed any care plans for Resident 1 prior to 06/26/2024.

Resident 2

Review of Resident 2's records showed the facility admitted Resident 2 on [redacted]/2023.

Review of Resident 2's NSA, dated 11/28/2023, showed no signature by Resident 2 or Resident 2's representative.

On 06/27/2024 at 12:46 PM, Collateral Contact 2, legal representative for Resident 2, stated that they had not reviewed or signed any documentation from the ALF regarding care and services that was to be provided to Resident 2.

Resident 4

Review of Resident 4's records showed the facility admitted Resident 4 on [redacted]/2023.

Review of Resident 4's NSA, dated 11/28/2023, showed no signature by Resident 4 or Resident 4's representative.

On 07/01/2024 at 10:31 AM, Collateral Contact 3, legal representative for Resident 4, stated that they had not seen or signed any care plans for Resident 4 prior to 06/26/2024.

On 06/26/2024 at 1:11 PM, Staff A stated that Staff C, Director of Nursing Services, was responsible for conducting NSAs for all residents. Staff A stated that after Staff C conducts an assessment, they create the resident's NSA, and then the resident's family would be contacted quickly after that to notify them about the updated NSA and to have them sign their agreement.

This is an uncorrected deficiency previously cited on 03/19/2024.

Plan/Attestation Statement

Statement of Deficiencies	License #: 1977	Compliance Determination # 43286
Plan of Correction	THE COTTAGES AT MILL CREEK	Completion Date
Page 4 of 5	Licensee: MILL CREEK SPECIAL CARE COMMUNITY LLC	07/01/2024

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, THE COTTAGES AT MILL CREEK is or will be in compliance with this law and / or regulation on (Date) 8-10-24 .

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

Administrator (or Representative) — Date: 7/16/24

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to properly store prescription medications in 1 of 3 cottages (Cottage C- Rainier) . This failure placed all 39 residents at risk of ingesting prescription and topical medications.

Findings included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 03/19/2024, the ALF received a citation for this regulation. The ALF signed an attestation statement that the facility would have a system in place and the deficiency corrected by 05/03/2024.

Resident 3

Review of Resident 3's Negotiated Service Plan, dated 02/18/2024, showed the facility admitted Resident 3 on [redacted]/2022.

On 06/26/2024 at 11:16 AM, two bottles of Antifungal Powder with Miconazole Nitrate 2%, one bottle of Latanoprost Ophthalmic Solution (treats glaucoma, a condition in

which increased pressure in the eye can lead to gradual loss of vision), one bottle of Timolol Maleate Ophthalmic Solution (treats increased pressure in the eye) and one bottle of Antimicrobial First Aid Antiseptic (reduces the growth of harmful bacteria, viruses or fungi) was observed on a bookshelf unattended in Resident 3's room. The two bottles of antifungal powder and the two bottles of eye drops had a prescription label with Resident 3's name written on it.

During an interview on 06/26/2024 at 11:26 AM, Staff B, Resident Care Coordinator, stated that any medications that are prescribed by a doctor are kept locked in the medication cart.

During an interview on 06/26/2024 at 12:11 PM, Staff A, Executive Director, stated that they did not know why the medications were on the shelf in Resident 3's room.

Review of Resident 3's medication administration record for June 2024 showed Resident 3 had an order for Latanoprost Ophthalmic Solution, instill one drop in both eyes one time per day, Timolol Maleate Ophthalmic Solution, instill one drop in both eyes in the morning and Micro-Guard powder (treats fungal or yeast infections on the skin) to be applied topically twice a day for reddened skin.

This is an uncorrected deficiency previously cited on 03/19/2024.

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, THE COTTAGES AT MILL CREEK is or will be in compliance with this law and / or regulation on (Date) 8-10-24 .

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

Administrator (or Representative) — Date: 7/16/24

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

03/28/2024

Licensee: MILL CREEK SPECIAL CARE COMMUNITY LLC
THE COTTAGES AT MILL CREEK
13200 10TH DRIVE SE
MILL CREEK, WA 98012

RE: THE COTTAGES AT MILL CREEK License # 1977

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 03/19/2024 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Kimberley Ripley, Field Manager
Residential Care Services
Region 2, Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

You May:

• Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

• Please contact me at (360)651-6846.

Sincerely,

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

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 02/21/2024, 02/21/2024 and 02/28/2024 of:
THE COTTAGES AT MILL CREEK
13200 10TH DRIVE SE
MILL CREEK, WA 98012

This document references the following complaint numbers: 119709, 119115.

The following sample was selected for review during the unannounced on-site visit: 10 of 37 current residents and 1 former residents.

The department staff that inspected the Assisted Living Facility:

Christine Banta, ALF Licensor
Jodi Condyles, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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-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;

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to provide a safe, sanitary, well-maintained environment for 4 of 4 cottages (Cottage A, B,C, and D). This failure resulted in all 37 residents living in an unsanitary environment and placed them at risk of injury and a decreased quality of life.

Findings included…

On 02/21/2024 at 10:10AM, an ALF facility tour was completed. The ALF consisted of four single level cottages that were all secured memory care units. The following was observed:

Cottage A - Cascade

At 10:11AM, the hand railing located in the main facility hallway had dust, dirt, food particles and pieces of tissue setting on them.

At 10:11AM, six brown circular splatter stains ranging from 1/4 to 3/4 inch wide, were observed directly below the handrailing and alarm control panel in the living room.

On 02/21/2024 at 10:14 AM, Staff A, Executive Director, stated that night shift caregivers were supposed to be doing the cleaning, including the rails. Staff A stated that they would get it cleaned right away.

Cottage B – Olympic

At 10:24 AM, dried pieces of tissue paper 2 inches x 2 inches were covering the emergency

alarm control panel in the living room.

On 02/21/2024 at 10:24 AM, Staff A stated that they did not why it had bits of tissue on it.

At 10:28 AM, a 4-inch x 3-inch round hole was in the plaster board behind the washing machine exposing ply board and a dirt and dust crusted plastic water pipe.

At 10:33 AM, a 4-inch x 4-inch round hole in the plywood exposing the drain access point under the handwashing sink in the community bathroom, leaving the water piping exposed.

At 10:36 AM, the shower room door had a 5-inch diagonal crack under the doorknob exposing sharp edges of the door's wood panel.

On 02/21/2024 at 10:37 AM, Staff A stated that the replacement door was arriving on 02/22/2024.

In an interview on 02/28/2024 at 12:15 PM, Staff G, Caregiver, stated that a resident had become upset and kicked the shower room door cracking it.

Cottage C – Rainier

At 10:59 AM, a 4-inch x 5-inch piece of rubber base board trim was missing to the left of the bathroom door.

At 11:04 AM, the laundry room washing machine, counter and sink were stained with pink and brown, dried laundry soap.

At 11:09 AM, the drain underneath the kitchen sink was covered in a yellow/brown coating, with pieces of food particles stuck to the plastic mesh covering the drain. Small flies were in the drain, on the plastic mesh covering and were flying around inside the cabinet. When the door was initially opened, flies were on the left side cabinet door.

At 11:11 AM, a 55-inch x 36-inch gray utility mat on the floor at the entrance of the kitchen had three corners curled up creating a trip hazard.

Cottage D – Pacific

At 11:23 AM, the drain underneath the kitchen sink was stained with a brownish/yellow substance that appeared dried in some spots and wet in others.

At 11:25 AM, the 96-inch x 1-inch front trim of the kitchen counter was missing exposing dried glue used to adhere the counter tops.

At 11:31 AM, a 26-inch x 4-inch piece of rubber base board trim, to the left of the main entrance of the cottage hallway was missing,

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, THE COTTAGES AT MILL CREEK 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-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:

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

This requirement was not met as evidenced by:

Based on observation, record reviews and interviews, the Assisted Living Facility (ALF) failed to implement safe infection control practices when 4 of 6 staff (Staff A, C, D and E) had not been fit tested for a N95 respirator, and 1 of 4 medication carts (Cottage B's medication cart) had a sharps container with a lid that did not lock. This failure resulted in residents, staff, and visitors being placed at risk of contracting a infectious disease and a medication cart having an unsecured sharps container placing all residents in Cottage B at risk for a needle stick injury from a used needle.

Findings included...

Fit Testing

Review of WAC 296-842-15005 Conduct fit testing, the ALF was to provide, at no cost to the employee, fit test for all tight-fitting respirators on the following schedule: Before employees are assigned duties that may require the use of respirators and thereafter yearly.

Review of the Departmentof Health's Respiratory Protection Program for Long-TermCare Facilities (https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/healthcare-associated-infections/respiratory-protection-program)showed there were six components to the Respiratory Protection Program which included a Written Program, Respirator Medical Evaluation, Fit testing, Training, Record Keeping and a Program Evaluation.

Review of the ALF's policy "Respiratory Protection Program" dated 05/01/2023 showed that the facility was to provide training for the Respiratory Protection Plan and fit testing for all employees at time of hire, annually and when there had been a change in the employee's physical condition that would affect the fit of the N95 respirator.

Review of the ALF's Respiratory Protection Binder showed no documentation that medical evaluations or fit testing was completed for Staff A, Regional Operations Manager, Staff C, Medication Technician/Caregiver and Staff D, Medication Technician. Documentation showed Staff E, Medication Technician/Caregiver had been fit testing on 12/07/2022 which exceeded the annual review date.

In an interview on 02/22/2024 at 3:46 PM, Staff A stated that they have not been fit tested by the facility.

In an interview on 02/26/2024 at 4:23 PM, Staff A stated that the previous executive director had completed respiratory fit testing for facility staff and maintained the documentation in the Fit Testing binder. Staff A stated that if the documentation was not in the Fit Testing Binder the fit testing was not completed.

Unsecured Sharps Container

On 02/21/2024 at 10:31 AM, the lid to the sharps container attached to the medication cart in Cottage B - Olympic was observed without a locking lid. The sharps container was less than half full. The lid was missing the flap that prevented used sharp needles from spilling out. Without this flap, anyone would be able to stick their hand into the container.

On 02/21/20214 at 10:31 AM, Staff A, Executive Director, stated that they would get the sharps container changed immediately.

On 02/21/2024 at 10:35 AM, the medication technician was observed changing the sharps

container with a new one that had a working lid.

This is a recurring deficiency for WAC 388-78A-2610(1) previously cited on 05/23/2023 and 09/28/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, THE COTTAGES AT MILL CREEK 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-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to complete the national fingerprint background check upon hire for 2 of 6 sampled staff (Staff A and B). This failure resulted in all residents being placed at risk of harm by allowing staff with possible disqualifying convictions access to them.

Findings included…

Review of the ALF's employee files showed:

Staff A, Regional Operations Manager, was hired on 05/02/2022. Staff A's employee file showed no documentation of a fingerprint background check.

Staff B, Director of Nursing, was hired on 10/23/2023. Staff B's employee file showed no documentation of a fingerprint background check.

In an interview on 02/26/2024 at 9:16AM, Staff A stated that they did not have a fingerprint background check completed at the time of hire.

In an interview on 02/22/2024 at 3:53PM, Staff B stated that they thought they had fingerprints at some point but do not believe it was with this current 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, THE COTTAGES AT MILL CREEK 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 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training.

(1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

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

(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 record review and interview, the Assisted Living Facility (ALF) failed to ensure 3 of 6 staff (Staff B, C, and D) completed facility orientation prior to providing care. This failure resulted in Staff B, C, and D not receiving a timely orientation and placed all residents at risk for compromised care and safety.

Findings included…

Review of the ALF's employee files showed the following:

Staff B, Director of Nursing, was hired on 10/23/2023. Staff B’s employee file showed no

documentation of a completed facility orientation.

Staff C, Medical Technician/Caregiver was hired on 12/05/2023. Staff C's employee file showed no documentation of a completed facility orientation.

Staff D, Medical Technician/Caregiver was hired on 11/08/2022. Staff D's employee file showed a completed facility orientation on 10/23/2023, 11 months past the date of hire.

On 02/23/2024 at 4:07PM, Staff B stated that they did not complete a facility orientation at the time of hire.

On 02/23/2024 at 2:05PM, Staff C stated that they did not receive a facility orientation at the time of hire.

On 02/23/2024 at 3:52PM, Staff D stated that they had no memory of why the facility orientation was completed late.

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, THE COTTAGES AT MILL CREEK 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;

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living facility (ALF) failed to have a signed Negotiated Services Agreement for 2 of 10 samples residents (Resident 4 and 5). This failure resulted in Resident 4 and 5 not having a reviewed, approved and signed Negotiated Service Agreement by the legal representative and placed the resident and resident representatives at not being aware of or agreeing to the care plans.

Resident 4

Resident 4 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

Review of Resident 4's Negotiated Service Agreement dated 11/28/2023 showed no signature on the agreement by Resident 4's legal representative.

On 02/26/2024 at 11:42 AM, Collateral Contact 1 (CC1), Legal Representative for Resident 4, stated that they had not reviewed or signed any documentation from the facility regarding care that was to be provided.

On 02/28/2024 at 12:33 PM, Staff A, Regional Operations Manager, stated that Resident 4 did not have a signed Negotiated Service Agreement.

On 02/28/2024 at 12:41 PM, Staff B, Director of Nursing, stated that they did not have a signed Negotiated Service Agreement for Resident 4.

Resident 5

Resident 5 was admitted to the ALF on [redacted]/2022 with multiple diagnoses including [redacted] and [redacted].

Review of Resident 5's Negotiated Service Agreement dated 07/23/2022 showed no signature on the agreement by Resident 5's legal representative.

On 02/28/2024 at 12:33 PM, Staff A stated that Resident 5 did not have a signed Negotiated Service Agreement.

On 02/28/2024 at 12:41 PM, Staff B stated that they did not have a signed Negotiated Service Agreement for Resident 5.

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, THE COTTAGES AT MILL CREEK 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 388-112A-0220 What is safety training, who must complete it, and when should it be completed?

(2) The following individuals must complete safety training:

(a) All long-term care workers who are not exempt from certification as described in RCW 18.88B.041 hired after January 7, 2012, must complete three hours of safety training. This safety training must be provided by qualified instructors that meet the requirements in WAC 388-112A-1260 .

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:

(a) Orientation and safety;

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure 1 of 6 staff (Staff D) completed Orientation and Safety prior to working with residents. This failure resulted in all residents being placed at risk for compromised care and quality of life.

Finding included…

Review of staff flies showed.

Staff D was hired on 11/08/2022. Staff D's employee file showed a completed Orientation and Safety on 05/11/2023.

On 02/26/2024 at 9:10 AM Staff A, Regional Operations Manager, stated that they did not know why Staff D’s Orientation and Safety was not completed prior to working with

residents.

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, THE COTTAGES AT MILL CREEK 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-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 6 sampled staff (Staff B, C, and F) were screened for tuberculosis (TB) (a bacterial infection that affects the lung tissue) within three days of hire. This failure resulted in all residents being at risk for possible exposure to a communicable disease.

Findings included:

Review of the ALF's employee files showed:

Staff B, Director of Nursing, was hired on 10/23/2023. No documentation of a completed TB test was found in the employee's file.

Staff C, Medication Technician/ Caregiver, was hired on 12/05/2023. No documentation of a completed TB test was found in the employee's file.

Staff F, Caregiver, was hired on 01/22/2015. No documentation of a completed TB test was found in the employee's file.

On 02/23/2024 at 3:52 PM, Staff C stated that they had a TB test at a prior employer and was not sure if they gave it to the executive director upon hired. They did not complete a new TB test upon hire.

On 03/05/2024 at 11:33 AM, Staff F stated that they were hired so long ago they cannot remember if they gave a TB test to the facility upon hire or even had one.

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, THE COTTAGES AT MILL CREEK 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 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

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.

This requirement was not met as evidenced by:

Based on record review and interview the Assisted Living Facility (ALF) failed to ensure 2 of 6 staff members (Staff E and F) had 12 hours of continuing education. This failure resulted in Staff E and Staff F not having the required continuing education hours, placing all residents at risk due to staff not being qualified to provide care.

Findings included…

Review of the ALF's employee files showed:

Staff E, Medication Technician/Caregiver, was hired on 04/02/2018. Staff E's file showed no continuing education hours.

Staff F, Caregiver, was hired on 01/22/2015. Staff F's file showed no continuing education hours.

On 02/23/2023 at 9:16 AM, Staff A, Regional Operations Manager, stated that whatever documentation was in the employees file is what the facility had. Staff A was unable to find any further continuing education documentation for Staff E or Staff F.

On 03/05/2024 at 11:33 AM, Staff F stated that they did not know how many continuing education hours they had but what would be in their employee file is what had been completed.

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, THE COTTAGES AT MILL CREEK 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 388-112A-0400 What is specialty training and who is required to take it?

(3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula:

(a) Developmental disabilities specialty training as described in WAC 388-112A-0420 ;

(b) Dementia specialty training as described in WAC 388-112A-0440 ;

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:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure 2 of 6 staff (Staff B and Staff E) completed specialized dementia and mental health training. This failure resulted in Staff B and Staff E not being trained to provide care for residents with [redacted] or [redacted] diagnoses and placing residents at risk of not receiving proper care.

Findings included…

The ALF's Resident Characteristic Roster dated 02/21/2024, showed 39 residents living in the ALF with [redacted] and [redacted] diagnoses.

Review of the ALF's employee files showed:

Staff B, Director of Nursing, was hired on 10/23/2023. Staff B's employee file showed no documentation of a completed dementia or mental health training.

Staff E, Caregiver, was hired on 04/02/2018. Staff E's employee file showed no documentation of a completed dementia training.

On 02/22/2024 at 3:52 PM, Staff B stated that they were not aware they had to complete the specialized dementia and mental health training and had not completed it.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons;

and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to keep medications secured in Cottage C (Rainier) when a medicine cup with a medicated powder was left on a windowsill in a Resident 9's room. This failure resulted in an unsecured prescription medication and placed the safety of all residents in Cottage C at risk of accidentally ingesting a prescription topical medication.

Findings included…

Resident 9

Review of the Negotiated Service Plan, dated 01/25/2024, showed resident 9 was admitted on [redacted]/2017 with multiple diagnoses including [redacted] and [redacted].

On 02/26/2024 at 11:50 AM, a medicine cup with white powder was observed on a windowsill unattended in a Resident 9's room. The medicine cup had Resident 9's name written on it.

On 02/26/2024 at 12:03 PM, Staff B, Director of Nursing, stated that the powder in the medication cup could be an antifungal powder but was not sure. Staff B stated that they were not sure how long the medication cup had been on the windowsill.

Review of Resident 9's medication administration record for February 2024 showed Resident 9 had an order for Miconazole Nitrate powder to be applied topically twice a day to treat a rash.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2210 Medication services.

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

(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 :

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to implement a system that promotes safe medication administration for 1 of 1 resident (Resident 1). This failure resulted in the medication technician walking away without observing Resident 1 taking their medications and placed Resident 1 at risk of not taking all their prescribed medications.

Findings included…

Resident 1

Review of the assessment, dated 01/24/2024, showed Resident 1 was admitted to the ALF on [redacted]/2019 with multiple diagnoses including dementia with [redacted], and [redacted]. The assessment showed Resident 1 needed staff administration with all medications.

Record review of the nurse delegation documents for Resident 9, dated 12/12/2023, showed step by step instructions on how to administer oral medications. These steps included having the resident sit upright and give with a glass of fluid and ensure that the medications are swallowed.

On 02/21/2024 at 10:53 AM, Staff D, Medication Technician, was observed handing a medication cup full of medications to Resident 1. Resident 1 was fully reclined in a recliner. While Resident 1 was observed pulling themselves up to reach for their cup of water, Staff D was observed at the medication cart across the room with their back turned away from Resident 1. Staff D started preparing medications for the next resident.

Record review of the Medication Administration Record for February 2024 showed Resident 1 took the following medications: acetaminophen 500 milligrams (mg) (pain reliever),

amlodipine (treats high blood pressure) 5mg, atorvastatin (lowers cholesterol) 40mg, divalproex (used to treat delusional disorders) 125mg, furosemide (treats fluid retention) 40mg, melatonin (helps regulate sleep) 3mg, memantine (treats symptoms related to Alzheimer's Disease)10mg, potassium (supplement) 10 milliequivalents, quetiapine (treats agitation), terazosin (treats urinary retention) 2mg, and Vitamin B-12 (supplement) 2500 micrograms.

On 02/21/2024 at 10:55 AM, Staff D stated that they did give Resident 9 their medications. Staff D was unable to state why they walked away before Resident 1 had taken their medications.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

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

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

(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.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to have an assessment for 2 of 2 Residents (Resident 3 and 10) for use of the siderails on their bed. This failure placed both residents' safety at risk for entrapment.

Findings…

Review of the ALF's policy "Bed/Side Rails" dated 02/01/2015, showed any resident requesting the use of side rails will be assessed at move in, at each assessment, and periodically as deemed necessary by license nurse. The LN will assess that resident is able

to safely use bed rails to assist in transfer/bed mobility. The LN will assess to ensure that bedrails do not pose a safety risk by allowing resident to get head, neck, or limbs stuck in rails or in between rails and mattress.

Resident 3

Review of the assessment, dated 10/16/2023, showed Resident 3 was admitted with multiple diagnoses including [redacted], and [redacted].

On 02/22/2024 at 2:45 PM, a bed side rail was observed on the left side of the bed. The left side of the bed was pushed up against the wall. There was another side rail attached on the right side of the bed in the down position.

On 02/26/2024 at 11:37 AM, the left side rail on Resident 3's bed was in the up position.

On 02/23/2024 at 2:57 PM, Staff B, Director of Nursing, stated that they did not have an assessment or an order for the side rails.

Resident 10

Review of Resident 10's face sheet showed they were admitted to the ALF on [redacted]/2020 with multiple diagnoses including [redacted] and [redacted].

On 02/28/2024 at 12:23 PM, side rails were observed in both sides of Resident 10's bed in the up position.

On 02/28/2024 at 12:24 PM, Staff H, Resident Care Coordinator, stated that the staff did use the side rails when Resident 10 was in bed.

On 02/28/2024 at 12:36 PM, Staff B stated that they did not have an assessment for use of a bed rail for Resident 10. Staff B stated that hospice services delivered both beds with side rails and assumed that meant there was an order.

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to submit the name and date of birth background check within one business day for 3 of 6 staff (Staff A, E and F). This failure resulted in residents being placed at risk of being cared for by an employee with a disqualifying background.

Findings included…

Review of the ALF's employee files showed:

Staff A, Regional Operations Manager, was hired on 05/02/2022. Staff A's employee file showed the name and date of birth background check was completed on 10/05/2022, 156 days after the date of hire.

Staff E, Caregiver, was hired on 04/02/2018. Staff E's employee file showed the name and date of birth background check was completed on 08/17/2022, 4 years, 4 months and 15 days after the date of hire.

Staff F, Caregiver, was hired on 01/22/2015. Staff F's file showed the name and date of birth background check was completed on 08/15/2022, 7 years, 6 months and 24 days after the date of hire.

In an interview on 2/22/2024 at 3:31 PM, Staff A stated that they were not certain why there was a delay in having the name and date of birth background checks completed.

In an interview on 03/05/2024 at 11:33 AM, Staff F stated that they were fairly sure they did their background check when they were hired but had been so long ago, they are not certain. Staff F stated that if it was not in their employee file then they can't be sure.

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