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

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) 24869 (Completion Date 06/05/2023) and 21573 (Completion Date 04/26/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/05/2023 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-2240

The Department staff who did the on-site verification:
Christine Banta, Community Complaint investigator

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

Residential Care Services
Investigation Summary Report

Provider/Facility: THE COTTAGES AT MILL CREEK
Provider Type: Assisted Living Facility
License/Cert.#: 1977
Intake ID: 74394
Compliance Determination #: 21573
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 03/24/2023 through 04/26/2023
Complainant Contact Date(s): 03/22/2023

Allegation(s):

It was alleged...
1. The Named Resident (NR) left the locked memory care unit two times.
2. There was medication confusion and the NR had been out of medication for three to four days.
3. There was no one that was doing the activities for the residents.
4. The facility was short staffed and as a result, NR was not getting the care they needed.

Investigation Methods:

Sample:	Total residents: 40 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members Administrator
Record Reviews:	Incident investigation Facility policies Physician order summary Physician order Assessment Progress notes Care plan Medication administration records Admission agreement

Investigation Summary:

It was determined...

1. The facility investigated the incidents and all parties were notified. The facility called 911 and together with law enforcement they looked for the NR. The NR's POA was notified and went to the facility. The police found and brought NR to the facility. The ALF removed a table in the courtyard the NR used to climb over the fence. No failed practice was found.
2. The facility ran out of NR's medications while waiting for a new physician order for their medication change. The facility failed to obtain the medication in a timely manner resulting to the NR not getting the prescribed medications. Failed practice was identified. WAC 388-78A-2240 Nonavailability of medications.
3. The facility had a calendar for activities in place that showed activities were being offered. Observation showed residents were given activities by the caregivers. The NR was provided with football CD's and videos at the NR's request. The NR was provided with options and encouraged to participate in activities. No failed practice.
4. Observation, interview, and record review showed the facility was providing the care identified in the NR's Individualized Service Plan. The facility was following the NR's care plan at the time of the incidents. The facility had been coordinating and communicating with the NR's family and primary care doctor regarding NR's behavior. No failed practice.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: THE COTTAGES AT MILL CREEK
Provider Type: Assisted Living Facility
License/Cert.#: 1977
Intake ID: 72684
Compliance Determination #: 21573
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 03/24/2023 through 04/26/2023
Complainant Contact Date(s):

Allegation(s):

It was alleged...
The Named Resident (NR) eloped.

Investigation Methods:

Sample:	Total residents: 40 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Activities Resident rooms Staff to resident interactions Resident to resident interaction
Interviews:	Identified resident Nursing staff Residents Family members Administrator
Record Reviews:	Incident investigation Facility policies Physician order summary Physician order Assessment Progress notes Care plan Medication administration records Admission agreement

Investigation Summary:

It was determined:
The facility investigated the incident and stated that the NR had been agitated prior to leaving the ALF. The facility found out that the NR may have climbed over the fence at

the back of the cottage and left. NR was found wet on a rainy evening and brought back by the police. The ALF placed the NR on alert charting and increased check-ins. The ALF moved the table that was used to climb over the fence.

Interview and review of records showed that the NR had missed medications for agitation due to the ALF not ensuring the reorders were obtained. Failed practice identified. WAC 388-78A-2240 Nonavailability of medications.

Conclusion / Action:

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

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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 an unannounced on-site complaint investigation on 03/24/2023 and 04/10/2023 of:

THE COTTAGES AT MILL CREEK
13200 10TH DRIVE SE
MILL CREEK, WA 98012

This document references the following complaint number(s): 74394, 72684

The following sample was selected for review during the unannounced on-site visit: 3 of 40 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

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.

Kim Rojo — Residential Care Services

4/28/23 — 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.

X Laura Williams
Administrator (or Representative)

X 05/10/2023
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to obtain, provide, and administer prescribed medications related to behavioral disturbance and for multiple diagnoses for 2 of 3 sampled residents, (Resident 1 and 2). This placed resident 1 and 2 at risk for behavioral issues, increased agitation, and health issues.

Findings included...

The facility's policy titled, "Medication policy" dated 05/03/2021, showed the resident has the right to choose an alternate pharmacy; however, if the alternate pharmacy is not able to provide services equal to that of "Pro-Pac- Payless (Facility master pharmacy), then the facility will provide these services to the alternate pharmacy through the master pharmacy for a charge of $150.00 per month.

Resident 1

Resident 1 was admitted on [redacted]/2022 with multiple diagnoses to include [redacted] and [redacted].

Records review of Resident 1's Individual service plan dated 03/24/2023, showed Resident 1 was assessed as requiring medication assistance and the facility staff would order, maintain all medications available, and assist resident medication according to physician order and resident preference.

In an interview on 04/04/2023 at 4:35 PM, Staff A stated that Veterans' Administration (VA) pharmacy was providing the medications for Resident 1.

Record review of Resident 1's Medication Assistance Record (MAR) dated 03/24/2023, showed that Prazosin HCL oral capsule one mg two times daily was ordered and started on 01/27/2023, as well as, Mirtazapine 30 mg 0.5 tablet given at bedtime and started on

11/10/2022. The MAR showed that Resident 1 did not receive the prescribed dose of Prazosin HCL seven times in March on 03/06/2023 through 03/09/2023. Resident 1 did not receive Mirtazapine 30 mg 0.5 tablet for two days in March, on 03/14/2023 and 03/15/2023. The medications were marked as medication not available (NA) on those respective dates.

An interview on 04/26/2023 at 10:38 AM, Staff F, Resident Care Coordinator, stated that Veteran's Administration (VA) pharmacy provides for Resident 1's medication. The facility has to call the VA pharmacy for the refill of the prescription. Resident 1 or the representative had no role in obtaining the medication but is only required to pay for the co-pay.

Record review of an ALF agreement titled, "MONTHLY RATE and ADMISSION AGREEMENT MEMORY CARE" which was signed and dated on 11/02/2022 by the Facility's representative and Resident's representative. The agreement showed the ALF was responsible for obtaining and providing the required medication in the event that a resident runs out of medication and the family member or its alternate designee cannot immediately fill the prescription. The facility would contact it's master pharmacy that would provide the required medication.

Resident 2

Resident 2 was admitted on [redacted]/2022 with multiple diagnoses to include [redacted].

Record review of a Resident Rental and Admission Agreement dated 11/11/2022 and signed by Resident 2 showed in the event that a resident runs out of medication and the family member, or its alternate designee cannot immediately fill the prescription, the facility was responsible for obtaining and providing this required medication. The facility would contact it's master pharmacy that would provide the required medication.

Record review of an assessment dated 12/08/2022 showed that Resident 2 was assessed as requiring medication assistance and the facility staff would order, maintain all medications available, and assist the resident with medications according to the physician's order and resident preference.

Record review of Resident 2's MARs dated 03/24/2023 and 04/05/2023 showed that Resident 2 was not given the following prescribed medications on the following dates because the medications were not available:
1.Melatonin tablet 3 mg 1 tablet at bedtime related to mild dementia with behavioral disturbance. Medications were not available;
December 2022 for 20 days on 12/4/22 through 12/14/22 and 12/23 through 12/31/22.
January 2023 for 31 days on 01/01/23 through 01/31/2023.
February 2023 for 14 days on 02/01/23 through 02/14/23.

2.Aspirin tablet 81 mg by mouth one time a day for prophylaxis. Medications were not available;
December 2022 for 20 days on 12/06/22 through 12/15/22; and 12/23/22 through 12/31/22.
January 2023 for 31 days on 01/01/23 through 01/31/23.
February 2023 for 28 days on 02/01/23 through 02/28/23.
March 2023 for 15 days on 03/01/23 through 03/15/23

3.Vitamin D3 tablet 1000 units by mouth one time a day as supplement. Medications were not available;
December 2022 for 19 days on 12/06/2022 through 12/16/2022; and 12/23/22 through 12/31/22.
January 2023 for 31 days on 01/01/23 through 01/31/23.
February 2023 for 28 days on 02/01/23 through 02/28/23.
March 2023 for 15 days on 03/01/23 through 3/15/23.

4.Polyethylene Glycol 3350 kit 1 pack by mouth for constipation. Medications were not available;
December 2022 for 6 days on 12/07,13,14, 28, 29 and 30,2022.
January 2023 for 31 days on 01/01/23 through 01/31/23.
February 2023 for 1 day on 02/01/23.

5.Seroquel fumarate oral tablet 25 mg two times a day for thought process. Medications were not available;
March 2023 for five times on 03/04 (morning and evening dose); 5; 11,12, 2023 (evening doses).

6.Duloxetine capsules 30 mg one capsule a day related to mild dementia with behavioral disturbance. Medications was not available on 03/04/2023.

In an interview 04/04/2023 at 11:10 AM, Collateral contact 1(CC1) stated that he was not informed that Resident 2 was not receiving his prescribed medications.

In an interview on 04/04/2023 at 11:23 AM, Staff F, Resident care manager (RCM), stated that they don't provide the medications and they would have to continue to contact the residents' representatives to get the medications.

In an interview on 04/04/2023 at 4:15 PM, Staff A, Executive director (ED), stated that the facility will get medications from the ALF's pharmacy if residents who were not using the ALF's preferred pharmacy runs out while waiting for refill. Staff A stated that she had no idea what the former ED did before Staff A became the ED.

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) 05/23/2023.

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

Laura Williams
Administrator (or Representative)

05/10/2023
Date

Mill Creek Special Care Community LLC
PLAN OF CORRECTION FOR SOD Dated April 28, 2023

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:
Based on interview and record review the Assisted Living Facility (ALF) failed to obtain, provide, and administer prescribed medications related to behavioral disturbance and for multiple diagnoses for 2 of 3 sampled residents, (Resident 1 and 2). This placed resident 1 and 2 at risk for behavioral issues, increased agitation, and health issues.

Plan of Correction:

- Resident 1 is no longer a resident of the facility due to discharge
- Director of Nursing, Resident Care Coordinator and Assistant Executive Director at time of incident no longer with facility
- New DNS training on nursing responsibilities to include new admissions and unavailable medications
- Retraining of Policy and Procedures with Resident Care Coordinator and Resident Care Manager:
    - Family Assistance with Medication/Treatment
    - Medication Unavailable