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

01/12/2024

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 # 1977

Dear Administrator:

This document references Compliance Determination 31651 (01/11/2024), which included complaint number(s) 102363.
The Department completed a complaint investigation of your Assisted Living Facility on 01/11/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Karen Glover, Complaint Investigator

Consultation:

WAC 388-78A-2180 Activities. The assisted living facility must:

(1) Provide space and staff support necessary for:

(a) Each resident to engage in independent or self-directed activities that are appropriate to the setting, consistent with the resident's assessed interests, functional abilities, preferences, and negotiated service agreement; and

(b) Group activities at least three times per week that may be planned and facilitated by caregivers consistent with the collective interests of a group of residents.

Interviews revealed the caregivers at the Assisted Living Facility (ALF) are responsible for conducting the activities each day for the residents, along with multiple other

responsibilities during their shifts. Interviews revealed at times the caregivers are too busy to get all of their tasks done and activities are not completed as scheduled. Four collateral contacts reported being in the ALF regularly and all reported never seeing residents engaged in an activity. This places the residents at risk of not receiving meaningful activities as scheduled.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:

- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:

- Inspect the facility to determine if you have corrected all deficiencies.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

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:
  - What specific deficiency or deficiencies you disagree with;
  - Why you disagree with each deficiency; and
  - Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - 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,

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: 102363
Compliance Determination #: 31651
Region/Unit #: RCS Region 2 / Unit A
Investigator: Karen Glover
Investigation Date(s): 10/26/2023 through 01/11/2024
Complainant Contact Date(s): 10/24/2023, 10/25/2023

Allegation(s):

1. No staff available on multiple occasions in the a cottage. Family has had to go to another cottage to find staff. Staffing conditions deteriorate after 4:30pm on weekdays and all shifts on the weekends.
2.The Named Resident (NR) has lost a considerable amount of weight.
3.The facility had not notified the NR's medical provider regarding the NR's weight loss. The NR has had severe diarrhea that has contributed to the weight loss and the dietary needs not being met by the facility.
4.The NR was receiving the wrong amount of medication.
5.The NR's clothing items and personal items have gone missing.
6. A resident was observed to be spreading fecal matter on the walls, floors and other surfaces in the common area of the cottage. Toilets have been found multiple times covered in fecal matter.
7. Breakfast dishes were found stacked on the table and kitchen counters.
8. Residents were found seated in chairs with their heads down and relatively unresponsive.

Investigation Methods:

Sample:
Total residents: 40
Resident sample size: 4
Closed records sample size: 0

Observations:
Identified resident
Residents
Activities
Dining
Resident rooms
Staff to resident interactions

Interviews:
Identified resident
Nursing staff
Residents
Family members
Housekeeping staff
Kitchen staff
Administration

Record Reviews: Weight records
Facility policies
Staff patterns
Negotiated service agreement
Medication Administration Records

Investigation Summary:

1. On an unannounced visit staffing was found in each cottage. Review of staffing schedules showed staff were scheduled each day. No failed practice was identified.
2. The NR lost 11.5 pounds over the last year. The facility had notified the MD regarding the weight loss beginning on 01/23/2023. Review of the meal monitor showed the NR ate between 75-100% of their meals. The NR was receiving meal replacement shakes daily. No failed practice was identified.
3. Interviews revealed no evidence of the NR having diarrhea. Reviewed 3 months of bowel monitoring with no documentation of diarrhea. The ALF is following the diet as directed by the medical provider and the NR's care plan. No failed practice was identified.
4. Record review showed the NR was receiving their medication as ordered by the medical provider. The NR was receiving consistent evaluations from the medical provider and psychiatric/mental health team. No failed practice was identified.
5. The admission agreement showed the facility was not responsible for lost or misplaced items. Families were encouraged to label all pieces of clothing. Laundry was completed for each resident individually and placed back in their room. Memory care residents wander in and out of rooms making it difficult at times to account for clothing. No failed practice was identified.
6. During an unannounced visit, the facility bathrooms were observed and found to be clean. No failed practice was identified.
7. During an unannounced visit right after lunch, observation showed only dirty dishes from lunch were found in the sink and plates had not been cleared from the tables. Caregivers were tending to residents right after lunch. No failed practice was identified.
8. During an unannounced visit, residents were found participating in activities. The activity calendar was posted for the current month. The caregivers in each cottage are responsible for following the activity calendar. Interviews revealed that the caregivers are responsible for doing activities and some days they do not have the time to complete activities as scheduled. Four collateral contacts reported being in the ALF regularly and all reported never seeing residents engaged in an activity. Consultation was written for WAC 388-78A-2180.

Conclusion / Action:

- ☐ Failed Provider Practice Identified / Citation(s) Written
- ☒ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A