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) 41216 (Completion Date 05/16/2024) and 33574 (Completion Date 03/13/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/16/2024 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-2371-1, WAC 388-78A-2371-3, WAC 388-78A-2410-9

The Department staff who did the on-site verification:
Wesler Dumecquias, Community Complaint Investigator

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

Sincerely,

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: 108171
Compliance Determination #: 33574
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 12/07/2023 through 03/13/2024
Complainant Contact Date(s): 12/01/2023

Allegation(s):

1. The Named Resident (NR) had a fall on 11/20/2023 and proper notification was not provided.
2. The NR was not provided the care needed by the Assisted Living Facility (ALF) which resulted in kidney failure.
3. The NR had fallen several times. The NR laid on the floor for several hours yelling for help and nobody came for help.
4. The NR supposedly had a bed alarm on their bed and on the wall, but the alarm never worked. The ALF said the alarms were turned off.
5. The NR had bedsores.
6. The ALF did not provide the NR with proper food and water. The NR reports being hungry and thirsty.
7. The ALF did not provide fresh fruits, vegetables, and meat.
8. The ALF were not cutting the NR's nails and hair which resulted in them doing it resulting in a bad cut.

Investigation Methods:

Sample:
Total residents: 40
Resident sample size: 3
Closed records sample size: 1

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

Interviews:
Nursing staff
Residents
Family members
Administrators

Record Reviews:
Facility policies
Incident investigation
Menu
Email communications with the facility administrators.
Facesheets

Care plan
Hospital Records
EMS transcript and medical records.
911 audio recording

Investigation Summary:

1. The Named Resident had a fall on 11/21/2023. The NR sustained a bump on their forehead and a skin tear on their arm. The NR stated that they were reaching for candies on a nightstand and slipped onto the floor. The ALF staff called 911 and the NR was transported to the Emergency room for evaluation and treatment. Record show that a family member was notified on 11/21/2023 at 23:12 PM.
2. Interview and review of records indicated that the NR had been eating their meals 50% to 100%. The ALF served water during meals and brought water to them, which was placed on their table by their bed before bedtime. The NR requests and was served sugar free hot coco per their request. The family supplies the NR with soda drinks. Record review of hospital records (hospital records) showed the NR was admitted with Acute Kidney disease- AKD (a condition when an abrupt reduction in kidneys' ability to filter waste products occurs within a few hours or a few days). The hospital records showed the NR AKI was suspected to be due to "chronically (persisting for a long time or constantly recurring) poor oral intake and chronic treatment with diuretics (is any substance that promotes diuresis, the increased production of urine) for the Chronic Heart Failure (A progressive heart disease that affects pumping action of the heart muscles. This causes fatigue, shortness of breath). The hospital records showed the hospitalist doctor suspected the use of contrast dye to have contributed to the kidney problem. The Hospital records showed the NR reported they had good oral intake.
3. Records reviewed showed the NR had 3 prior falls on 02/27/2023, 04/24/2023, and 06/10/2023. The Incidents were investigated and abuse and neglect were ruled out.
4. The ALF said the alarms were turned off. The NR's room call button located by the wall was operation and functioning when tested during the unannounced visit. On interview, the ALF staff determined that the volume of the alarm was turned to low volume. The ALF double checked the alarm volume and ensured that it was in full volume.
5. Record review of the Department of Social Health Services Home Community and Services dated 11.20.2023, Palliative Care plan Assessment dated 11/15/2023, Service plan dated 07/27/2023, and hospital records dated 11/21/2023 showed the NR's skin was clean, dry and intact. Interview and record review showed the NR had a rash on their groin area which were treated with Antifungal medications. The ALF's progress Notes dated 11/19/2023 showed the rashes in their groin area were resolved and the antifungal medications. There was no documentation of a completed ongoing weekly rounds as required by the ALF's policy. Sampled residents were assessed as having compromised skin integrity and wounds. The ALF policy showed the Licensed Nurse was to complete ongoing wound rounds on residents with wounds/compromised skin integrity no less than one time per week until resolved. Results will be documented in resident record. There was no documentation showing weekly rounds were completed for the sampled residents records. Failed practice was identified for the ALF in not following their protocol of documenting in the resident records an ongoing weekly rounds and documentation. A citation was issued for non compliance with WAC 388-78A-2410 Content of resident records.
6. The ALF serves water during meals and brings water by their table before bedtime. The NR requested and was served sugar free hot coco and was able to communicate their needs. The family supplied the NR with soda drinks and chocolate candies. The NR was able to verbalize food preference.
7. The ALF made changes in their menu starting 01/01/2024 and were serving fruits daily, on a weekly basis for breakfast, 2 x for lunch, and Residents had the options to

request if they wanted more. Review of the Menu showed varieties of foods were served based on the weekly menu. Observation at mealtime showed the ALF were following the Menu as posted. Interview indicated the family brought bananas and were offered to the NR. The NR would refuse at times and the banana were thrown away due to spoilage.
8. Record review showed the ALF coordinated podiatry services and the NR was seen by a provider on 12/01/2023. Debridement and trimming of nails was done by the provider. The NR's care plan provided for the nail services to be done either by the ALF's licensed nurse or a podiatrists.

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: 110180
Compliance Determination #: 33574
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 12/07/2023 through 03/13/2024
Complainant Contact Date(s): 01/03/2024

Allegation(s):

1. The Named Resident (NR) had a fall, sustained a knot on their head and the Assisted Living Facility (ALF) staff refused to call 911.
2. ALF staff would not let the NR use the phone to call 911 and moved the phone to the other side of the room so the NR could not reach it.
3. The NR was dehydrated.
4. The NR had bedsores from lack of care.

Investigation Methods:

Sample:	Total residents: 40 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Activities Resident rooms Resident to resident interactions Staff to resident interactions
Interviews:	Nursing staff Residents Family members Administrators
Record Reviews:	Facility policies Incident investigation Menu Email communications with the facility administrators. Facesheets Care plan Hospital Records EMS transcript and medical records. 911 audio recording

Investigation Summary:

1. Interview and record review showed the NR sustained a new injury which

corroborated the NR's claim of having a fall. The ALF staff were informed but did not investigated the incident to identify the circumstances surrounding the incident , identify preventative measures, as well as to rule out abuse and neglect. Failed practice was identified and a citation was issued for noncompliance with WAC 388-78A-2371 Investigations.
2. The NR had a phone in their room beside their bed and was accessible for them. The NR was able to call 911 through the phone in their room.
3. Interview and review of records indicated that the NR had been eating their meals 50% to 100%. The ALF served water during meals and brought water to them, which was placed on their table by their bed before bedtime. The NR requests and would be served with sugar free hot coco per their request. The Family supplied the NR with soda drinks. The NR had creatinine level above baseline which was suspected due to poor fluid intake and used of water pills. The NR's creatinine level increased which could be what was termed as Contrast Nephropathy (is worsening of renal function after IV administration of radiocontrast and is usually temporary. Diagnosis is based on a progressive rise in serum creatinine 24 to 48 hours after contrast is given. Treatment is supportive). The NR had a contrast used on 11/22/23 for CT scan of the head and neck.
3. Record review of the Department of Social Health Services Home Community and Services dated 11.20.2023, Palliative Care plan Assessment dated 11/15/2023, Service plan dated 07/27/2023, and hospital records dated 11/21/2023 showed the NR's skin was clean, dry and intact. Sampled residents were assessed as having compromised skin integrity and wounds. The ALF policy showed the Licensed Nurse was to complete ongoing wound rounds on residents with wounds/compromised skin integrity no less than one time per week until resolved. Results would be documented in resident record. There was no documentation showing weekly rounds were completed for the sampled residents records. Failed practice was identified for the ALF in not following their protocol of documenting in the resident records an ongoing weekly rounds and documentation. A citation was issued for non compliance with WAC 388-78A-2410 Content of resident records.

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: 110546
Compliance Determination #: 33574
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 12/07/2023 through 03/13/2024
Complainant Contact Date(s):

Allegation(s):

1. The Named Resident (NR) had a fall, sustained bump on their head and staff did not know what and how it happened. The NR asked a Staff to call 911 but the staff refused to call 911. The family who was at the ALF were the once who called 911.
2. The ALF staff never informed the family of what happened.
3. The Named Resident (NR) had a stage 3 or 4 bedsore.
4. The NR had not been drinking enough fluid while at the ALF that caused his high creatinine.
5. The NR was observed on their bed laying with no pad on the floor, rail or anything to prevent the NR from falling.
6. The Call button in the NR's room was not working. The ALF staff informed the family that the NR would use a stick to call for help if their call button were not working.
7. The NR had a second fall after returning and staying from the hospital for 4 day7

Investigation Methods:

Sample:	Total residents: 40 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Activities Resident rooms Resident to resident interactions Staff to resident interactions
Interviews:	Nursing staff Residents Family members Administrators
Record Reviews:	Facility policies Incident investigation Menu Email communications with the facility administrators. Facesheets Care plan Hospital Records

EMS transcript and medical records.
911 audio recording

Investigation Summary:

1. Interview and record review showed the NR sustained a new injury which corroborated the NR's claim of having a fall. The ALF staff were informed but did not investigated the incident to identify the circumstances surrounding the incident , identify preventative measures, as well as to rule out abuse and neglect. Failed practice was identified and a citation was issued for noncompliance with WAC 388-78A-2371 Investigations.
2. Interview and record review showed the family were aware and were the ones who called 911 for the NR to be brought to the hospital.
3. Record review of the Department of Social Health Services Home Community and Services dated 11/20/2023, Palliative Care plan Assessment dated 11/15/2023, Service plan dated 07/27/2023, and hospital records dated 11/21/2023 showed the skin were clean, dry and intact. Sampled residents were assessed as having compromised skin integrity and wounds. The ALF policy showed the Licensed Nurse were to complete ongoing wound rounds on residents with wounds/compromised skin integrity no less than one time per week until resolved. Results will be documented in resident record. There was no showing of weekly documentation in the sampled residents records. Failed practice was identified for the ALF in not following their protocol of documenting in the resident records an ongoing weekly rounds and documentation. A citation was issued for non compliance with WAC 388-78A-2410 Content of resident records.
4. Interview and review of records indicated that the NR had been eating their meals 50% to 100%. The ALF serves water during meals and brings water by their table before bedtime. The NR requests and would be served with sugar free hot coco per their request. The Family supplies the NR with SODA drinks. The NR had creatinine level above baseline which was suspected due to poor fluid intake and used of water pills.
5. The NR was on hospice services and had a hospital bed equipped with a bed rail. Interview showed the ALF staff were to raise the bed rails only when the NR were to go to bed and sleep. The NR was no longer in the ALF for observation at the time of the unannounced visit.
6. 1. Interview and record review showed the NR sustained a new injury which corroborated the NR's claim of having a fall. The ALF staff were informed but did not investigated the incident to rule out abuse and neglect as well as the circumstances surrounding the allegation. Failed practice was identified and a citation was issued for non compliance with WAC 388-78A-2371 Investigations.

Conclusion / Action:

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

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 an unannounced on-site complaint investigation on 12/07/2023 and 01/19/2024 of:

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

This document references the following complaint number(s): 106132, 108171, 110180, 110546

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.

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-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;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to investigate, determine the circumstances, institute preventative measures, and document their findings and actions when 1 of 3 residents (Resident 1) had an had an unwitnessed fall and sustained an injury. This failure resulted in the ALF not being able to rule out abuse or neglect or to identify preventative measures for Resident 1's and placed the resident at risk for future falls.

Findings included...

Review of the Assisted Living Facility Guidebook Partners in Protection, dated February 2018, contained guidelines intended to assist facilities in developing and implementing policies and procedures to help prevent resident abuse, neglect, abandonment, significant injuries of unknown source, or personal and/or financial exploitation by any person. Chapter 2 and Appendix F showed State law required the assisted living facility to do a thorough investigation when there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident. For the facility to provide evidence of the thoroughness of the investigation the information must be documented. The investigation should include data collection to identify who, what, when and where. The data analysis should answer how and why of the incident.

Review of the ALF's policy "Reporting Incidences" dated 02/01/2015 showed CarePartners Senior Living will investigate all unexplained incidents and accidents that involve injury to residents. Investigations and interventions were to be completed by Licensed Nurse no more than 72 hours after the initial event.

Resident 1 was admitted on [redacted] 2021 with multiple diagnoses including [redacted] ([redacted]).

Review of Progress notes dated 11/29/2023 showed Resident 1 had a hematoma on the right side of their forehead that was open to air, skin tear to the top of their right hand and a small open area in their sacrum. The progress notes did not mention any injury on their left forehead.

Review of an incident report (IR) dated 12/02/2023 showed the family reported Resident 1 stated that they had a fall. The IR showed an ALF staff asked Resident 1 if they had a fall and Resident 1 stated they fell 2 times and hit both sides of their forehead. The IR showed Resident 1's family called 911 and Resident 1 was sent to the hospital.

Review of South Snohomish County Fire and Rescue Patient Care Record (Patient record) dated 12/02/2023 showed Resident 1 reported pain from where they had fallen 2 days prior. Resident 1's record showed the family observed a new abrasion on Resident 1's head and they were complaining of having a headache.

Review of Hospital records dated 12/03/2023 showed Resident 1 was seen at the emergency hospital for a fall. The Hospital records showed Resident 1 had "Hematoma on their right forehead with some bruising that looks older. Pressure looking abrasion type injury to left forehead".

On 02/12/2024 at 10:32 AM, Staff B, Executive Director, stated that the Director of Nursing Services (DNS), did an investigation.

On 02/12/2024 at 1:34 PM, Staff C, Director of Nursing Services (DNS), stated that they do not believe they investigated the incident because Resident 1's family were saying they fell but the ALF staff stated they were not aware Resident 1 had a fall. Staff C was unable to provide a copy of an incident report or an investigation during the unannounced visits on 12/07/2023, 12/21/2023, and 01/05/2024.

On 01/05/2024 at 3:00 PM, Staff D, Resident Care Coordinator stated that on 12/02/2023, Resident 1 informed them they hit their head on the side rail in their bed when they allegedly had the fall on 12/02/2023. Staff D stated that Resident 1 had a new bruising in their left forehead at the time of the alleged fall on 12/02/2023.

This is a recurring citation previously cited on 12/15/2021.

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-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(9) Documentation consistent with WAC 388-78A-2120 Monitoring resident well-being.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to document weekly skin observations in the residents' records for 3 of 3 residents (Resident 1, 2, and 3) who had wounds and were assessed to have compromised skin integrity. These failures placed the residents at risk for worsening skin issues, unmet care needs, and a decreased quality of life.

Findings included….

Review of the ALF's policy "Wounds- Skin Integrity" dated 10/07/2020 showed it is the policy of CarePartners Senior Living to assist each resident with maintaining healthy skin integrity as per assessed need. Each resident will be assessed for chronic, current, and potential skin conditions prior to admittance and with each full reassessment. Full body skin assessment will be completed as per each resident's approval to do so, and documentation made in resident chart and Negotiated Service Agreement (NSA). When providing hands-on activities of daily living assistance, staff will monitor and report any indication of altered skin integrity to Licensed Nurse (LN) for evaluation. The LN will complete ongoing wound rounds on residents with wounds/compromised skin integrity no less than one time per week until resolved. Results will be documented in resident record.

Resident 1

Resident 1 was admitted on [redacted]/2023 with multiple diagnoses including [redacted] ([redacted]).

Review of a NSA dated 12/07/2023 showed Resident 1's skin integrity was compromised and could be dry/thin/bruise easily. The NSA showed resident 1 required total staff assist with the application of lotion and/or skin protectant and the care Staff would have to notify the LN of any red, raised, discolored, or open areas. Resident 1 had current wounds requiring staff intervention. There was no direction showing what staff must do about the wounds.

Review of Progress Notes dated for October, November, and December 2023 showed Resident 1 had a slight rash in their groin and were prescribed antifungal cream. There was no documentation that showed ongoing wound rounds or compromised skin integrity assessments were completed.

On 03/12/2024 at 12:53 PM, Staff C, Director of Nursing, stated that she was only required to do weekly rounds when someone presented with any skin issues. Staff C stated that they do the skin checks on Wednesdays. Staff C stated that they only do skin checks if the caregivers inform them of any issues.

On 12/07/2023 at 3:40 PM, Staff F. Med Tech/ Caregiver stated that they would report to their LN if they observed any skin discoloration. Staff F stated that they observed pinkish discoloration on Resident 1's butt but did not report to the LN because they assumed it was normal.

Resident 2

Resident 2 was admitted with multiple diagnoses including [redacted] ([redacted]).

Review of a NSA dated 01/29/2024 showed Resident 2 had compromised skin and it could be dry/thin and bruise easily. Resident 2 required maximum assist to apply lotion and or protect the skin.

Review of Resident 2's Progress Notes for November and December 2023 did not show any documentation of a completed ongoing weekly rounds for Resident 2's compromised skin.

On 03/12/2024 at 1:00 PM, Staff C, Director of Nursing, stated that Resident 2's skin was compromised which would mean the skin would easily get skin tears. Staff C stated that the caregivers were their eyes and once they've been told of a skin issue, they would assess and document. Staff C showed part of Resident 2's care plan as there documentation.

Resident 3

Resident 3 was admitted on [redacted]/2022 with multiple diagnoses including [redacted].

Review of a NSA dated 11/26/2023 showed Resident 2 had compromised skin and could be dry/thin and bruise easily. Resident 3 requires total assist for the application of lotion and or protect the skin. Staff were required to notify the Licensed Nurse for any red, raised, discolored or open areas. The NSA showed that wound care (refers to specific types of treatment for wounds that break the skin) was initiated on 11/20/2023 but did not provide any details about the location or type of wound.

Review of Hospital Emergency Record dated [redacted]/2023 showed Resident 3 was seen and was admitted at the hospital due to unwitnessed fall with a head laceration on their scalp from the fall. Resident 3 returned to the ALF on [redacted]/2023.

On 01/18/2024 at 10:42 AM, Collateral Contact 2 (CC2) stated that they visited Resident 3 every other week and they observed Resident 3 with couple minor injuries on their nose and their Forehead. CC2 stated that they saw Resident 3 with a bandage on their forehead.

Review of Resident 3's Progress Notes for November 2023 did not show any documentation of an ongoing weekly rounds for Resident 2's compromised skin or wounds.

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