STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

11/04/2024

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) 49279 (Completion Date 10/24/2024) and 44005 (Completion Date 08/23/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/24/2024 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-2630-1-a, WAC 388-78A-2450-1-a

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,

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: 136261
Compliance Determination #: 44005
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 07/11/2024 through 08/23/2024
Complainant Contact Date(s): 07/10/2024

Allegation(s):
The Named Resident (NR) left the Assisted Living Facility (ALF) through the window. The Police located the NR approximately two hours later and returned the NR to the ALF.

Investigation Methods:

Sample:	Total residents: 39 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Activities Dining Resident rooms Windows
Interviews:	Nursing staff Residents Family members Maintenance staff
Record Reviews:	Incident investigation Facility policies progress notes. PCP referral Staffing

Investigation Summary:
The Assisted Living Facility (ALF) investigated the incident on 06/23/2024 and determined that the Named Resident (NR) may have removed their apartment window and jumped over the fence in the back yard, heading towards a busy street. The ALF called 911, and the Police found the NR in Everett about eight miles away from the ALF. The ALF failed to ensure the ALF staff monitored the NR at all times according to the ALF's alert charting in the NR's progress notes when the NR was able to leave the ALF unnoticed. The ALF staff did not report all of the incidents to the department's Aging and Disability Services Administration Complaint Resolution

Unit hotline. Failed practice was identified. A citation was issued for noncompliance with WAC 388-78A-2630 (1) (a) Reporting abuse and neglect and WAC 388-78A-2450 (1) (a) Staff.

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: 136607
Compliance Determination #: 44005
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 07/11/2024 through 08/23/2024
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) broke the Assisted Living Facility's (ALF) back patio fence on 06/28/2024, jumped over it and left the ALF. The Police located and brought back the NR.

Investigation Methods:

Sample:	Total residents: 39 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Activities Dining Resident rooms
Interviews:	Nursing staff Residents Family members Maintenance staff
Record Reviews:	Incident investigation Facility policies progress notes. PCP referral Staffing

Investigation Summary:
The Assisted Living Facility (ALF) investigated the incident 0n 06/28/2024 and determined that the Named Resident (NR) jumped over the ALF's fence while the ALF staff prepared the residents' breakfast. The ALF called 911, and the Police found the NR with the help of the family's tracker that the NR was wearing. The ALF failed to ensure the ALF staff monitored the NR at all times according to the ALF's alert charting in the NR's progress notes when the NR was able to leave the ALF unnoticed. The ALF did not report all the incidents to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline. Failed practice was identified. A citation was issued for noncompliance with WAC 388-78A-2630 (1)

(a) Reporting abuse and neglect and WAC 388-78A-2450 (1) (a) Staff.

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: 136990
Compliance Determination #: 44005
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 07/11/2024 through 08/23/2024
Complainant Contact Date(s): 07/11/2024

Allegation(s):

1. The Named Resident (NR) had been getting out and went missing three times while in the Assisted Living Facility (ALF).
2. The ALF's staff all went on break and the NR was able to break the fence of the ALF with their bare hands and left unnoticed.

Investigation Methods:

Sample:	Total residents: 39 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Activities Dining Resident care equipment Resident rooms
Interviews:	Nursing staff Residents Family members Maintenance staff
Record Reviews:	Incident investigation Facility policies progress notes. PCP referral Staffing

Investigation Summary:

1. The Named Resident (NR) had been actively exit-seeking since moving into the Assisted Living Facility (ALF) on [redacted]/2024. The ALF staff stated during interviews that they could not have kept the NR safe because the NR constantly looked for a way to escape. Records showed the NR had attempted to flee the secured unit many times but staff was able to redirect them. The ALF had three incident reports of the NR leaving the ALF. The ALF staff caught the NR several other times outside the secured Cottage. The ALF failed to provide the level of supervision that was in

the NR's negotiated service plan when the NR was able to get out of their Cottage multiple times. The ALF did not report the incident to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline. Failed practice was identified. A citation was issued for noncompliance with WAC 388-78A-2630 (1) (a) Reporting abuse and neglect and WAC 388-78A-2450 (1) (a). Staff.
2. The ALF staff were not on break at the time of any of the three documented incidents. The process for staff taking a break was to have another staff cover. The staff person working in the NR's cottage was not on break, but was assisting another resident. The ALF failed to ensure the ALF staff monitored the NR at all times according to the ALF's alert charting and as in the NR's progress notes. Failed practice was identified and a citation was issued for noncompliance with WAC 388-78A-2630 (1) (a) Reporting abuse and neglect and WAC 388-78A-2450 (1) (a) Staff.

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 07/11/2024 and 08/05/2024 of:

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

This document references the following complaint number(s): 136261, 136607, 136990, 138355

The following sample was selected for review during the unannounced on-site visit: 3 of 39 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-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline when 1 of 1 resident (Resident 1) left the ALF's secured memory care unit unsupervised on two occasions. These failures resulted in an unreported incident preventing the Department from reviewing the ALF's response when Resident 1 left the secure memory care facility and placed Resident 1 at risk for harm.

Findings included...

The ALF's policy on "ELOPEMENT- Missing Resident," dated 10/07/2020, showed the Executive Director or the License Nurse would report elopement to the Department of Social Health and Services Hotline (DSHS HOTLINE) within 24 hours when a resident leaves the ALF secured unit without supervision. The policy defined elopement as leaving protected and safe surroundings with no focused designation or the inability to return safely after exiting the facility.

Resident 1 was admitted on [redacted]/2024 with multiple diagnoses including [redacted] ([redacted]) and [redacted] ([redacted]).

A review of the progress notes dated 06/23/2024 showed Resident 1 eloped from the community around 8:00 PM after trying several times to escape. The Police brought Resident 1 back around 9:00 PM.

A review of the ALF's elopement incident report dated 06/29/2024 showed Staff F, Med Tech/Caregiver, discovered Resident 1 was missing from their room. The Paramedics

located the NR and was brought back to the ALF.

On 07/14/2024 at 2:42 PM, Staff B, Director of Nursing, stated that they were not able to report to the DSHS HOTLINE the missing resident incidents on 06/23/2024 because they forgot and the incident on 06/29/2024 because they were out of town.

A DSHS Hotline Tracking System review showed the missing resident incidents on 06/23/2024 and 06/29/2024 were not reported.

This is a recurring deficiency previously cited on 04/06/2022.

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-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

This requirement was not met as evidenced by:

Based on Observation, interview, and record review, the Assisted Living Facility (ALF) failed to provide 1 of 1 resident (Resident 1) with staff having the capability to provide the supervision as identified in the care plan. These failures to timely monitor Resident 1's whereabouts and behaviors resulted Resident 1 being able to leave the secured memory care premises unsupervised and unnoticed three times. These failures placed Resident 1 at risk of abuse, neglect, exploitation, and personal injury.

Findings included…

A review of the ALF's Elopement policy dated 10/07/2023 showed for purposes of this policy, elopement is defined as: The process of leaving protected and safe surroundings

with no focused designation, or the inability to return safely after exiting facility.

Resident 1 was admitted on [redacted]/2024 with multiple diagnoses, including [redacted] ([redacted]) and [redacted] ([redacted]). Resident 1 lived in Cottage B.

A review of the Assessment dated [redacted]/2024 showed Resident 1 had intermittent exit-seeking, pacing, and wandering behavior. Resident 1 had a history of leaving their home and headed to a highway.

A review of the Service plan dated 06/22/2024 showed Resident 1 had a diagnosis of [redacted], which required restricted egress. Access to the community at large without supervision would put Resident 1 at risk of harm, abuse, neglect, exploitation, or personal injury. Resident 1 was exit-seeking and needed "monitoring/supervision."

A review of alert charting dated [redacted]/2024 and 06/18/2024 showed Resident 1 had been trying to exit many times through the door of Cottage B and their apartment window on the evenings of [redacted]/2024 and 06/18/2024.

A review of alert charting dated 06/24/2024 showed Resident 1 was on alert charting for elopement and the ALF staff were to monitor the resident’s whereabouts and behaviors at all times.

A review of the ALF incident reports showed Resident 1 went missing three times on 06/23/2024, 06/28/2024, and 06/29/2024.

On 07/11/2024 at 3:16 PM, Staff D, Resident Care Coordinator, stated that Resident 1 had attempted several times to get out of the Cottage in the evenings of [redacted]/2024 but staff were able to redirect them back to the Cottage. Staff D stated that Resident 1 eloped and went missing again about three times. Resident 1 was actively exit-seeking, and staff constantly did 1:1 for them. Staff D stated that they thought Resident 1 was not appropriate in their setting because they actively and continuously tried to get out of the Cottage.

A review of the ALF's elopement incident report dated 06/23/2024 showed Resident 1 attempted to leave the ALF earlier in the day, 06/23/2024 twice by breaking (forcefully opening the window, which broke the Latch/lock) another resident's window in Cottage A and on the second instance by climbing on a box in the backyard of Cottages A and B. The ALF staff were able to redirect Resident 1 in these two instances. On the same day,

06/23/2024, at about 8:00 PM, the ALF staff discovered that Resident 1 was missing. The report showed Resident 1 wears an AngelSense Tracker (AngelSense includes a GPS tracking device, assistive speakerphone, live monitoring, and proactive alerting). The ALF staff was not able to locate Resident 1 and called 911. The Police arrived and went to search for Resident 1. The Police located Resident 1 in Everett and brought them back to the ALF sometime after 9:00 PM. The report showed Resident 1 walked out of the ALF's premises and got a ride with someone.

On 8/22/2024 at 2:37 PM, Staff D stated that on 06/23/2024, Staff F, Med tech/Caregiver, was assigned as both the Med Tech for Cottages A and B and also assigned as the Caregiver in Cottage B, where Resident 1 lives.

On 08/11/2024 at 5:23 PM, Staff F stated that they were assigned as the Med Tech for Cottages A and B on 06/23/2024. Staff F stated that Staff J was the caregiver on 06/23/2024 and Staff J was helping another resident in the bathroom when Resident 1 left the ALF. Staff F stated that they could not recall where they were at the time of the incident. Staff F stated that when Staff J assisted another resident in using the bathroom, no one was watching the other residents in Cottage B, including Resident 1. Staff F stated they went to look for Resident 1 but could not locate them. They called 911 and the Paramedics was able to locate Resident 1 and brought them back to the ALF. Staff F said Resident 1 went missing for about less than two hours.

A review of the staff schedule dated 06/23/2024 to 06/29/2024 showed Staff F was assigned as the evening MedTech and simultaneously the caregiver in Cottage B on 06/23/2024. The schedule showed no other staff assigned to Cottage B. Staff J was working as caregiver on 06//28/2024.

On 08/14/2024 at 2:48 PM, Staff J stated that they could not recall an incident of elopement on the evening of 06/23/2024 but could recall an incident one morning where Resident 1 jumped over the fence of Cottages A and B. Staff J could not recall the date.

On 07/12/2024, in an email, Collateral Contact 1 (CC1) stated that the Police found Resident 1 on 06/23/2024 on 16th St and Hoyt AVE, Everett, Washington, which was determined to be between 9.4 miles and 11.6 miles from the ALF. CC1 stated that they were able to locate Resident 1 because of the AngelSence tracker (provided by Resident 1's family). The Police brought Resident 1 back to the ALF around 10:45 AM on the same day.

A review of the ALF's elopement incident report dated 06/28/2024 showed Resident 1 was missing on 06/28/2024 at 7:45 AM. Staff E, MedTech, stated that Staff J, Caregiver from Cottage B, called them for help. Staff E immediately went to Cottage B and discovered the broken backyard fence between Cottages A and B. Staff E called 911.

The Police arrived, searched, located, and returned the NR to the ALF at 8:15 AM on the same day.

On 08/22/2024 at 2:37 PM, Staff D stated that Staff E was assigned as the Med Tech for all the ALF's four Cottages A, B, C, and D; Staff H and Staff J were the caregivers for Cottages A and B, respectively.

A review of the Staff schedule dated 06/23/2024 to 06/29/2024 showed Staff E was the assigned MedTech in the morning of 06/28/2024. Staff J was the morning caregiver in Cottage B, and Staff H, was the morning caregiver in Cottage A on 06/28/2024.

On 08/14/2024 at 2:48 PM, Staff J stated that they were in the kitchen in Cottage B preparing for breakfast when they heard a sound consistent with something breaking. Staff J stated that when they went to check where the sound came from, they saw Resident 1 had climbed the backyard fence in the shared yard at the back of Cottages A, and B. Staff J ran and tried to stop Resident 1, but they already jumped over the fence. Staff J called Staff E for help.

On 07/11/2023 at 3:40 PM, Staff E, Med Tech, stated that on 06/28/2024 around 7:45 AM, Staff J called them for assistance because Resident 1 was missing. Staff E stated that they went to look for Resident 1 but could not locate them. Staff E stated that Resident 1 could have jumped over the fence after Resident 1 broke it. Staff E stated they could not have kept Resident 1 safe due to their continuous exit-seeking. Staff E stated they tried their best to monitor the whereabouts and behavior of Resident 1.

On 07/11/2024 at 2:08 PM and 08/23/2024 at 9:47 AM, Staff H stated that they were working the morning shift on 06/28/2024 in Cottage A. Staff H stated that they were dishing out after breakfast when they heard a noise that something broke. They were watching outside from inside Cottage A when they saw Resident 1 walking outside. Staff H said that Staff J had told them they had seen Resident 1 already across the fence at the time of the incident.

On 07/11/2024 at 2:15 PM, Resident 1's apartment window was observed intact and equipped with an alarm. The top part of the fence at the back of the Cottages was partly destroyed, and the wooden parts of the fence were found on the ground close to the fence. Two chairs were found leaning on the fence, which was approximately one foot in height to the fence.

A review of the staff schedule dated 06/23/2024 to 06/29/2024 showed Staff F was assigned as the evening MedTech and, simultaneously, the caregiver in Cottage B on 06/29/2024.

A review of the ALF's elopement incident report dated 06/29/2024 showed Staff F

discovered Resident 1 was missing from their room on 06/29/2024. Staff E stated that they searched for Resident 1 but could not locate them. They called 911. The Paramedics arrived, searched, located the NR, and brought them back to the ALF.

On 08/11/2024 at 5:23 PM, Staff F stated that they were working as the MedTech for Cottages A and B, and at the same time, the caregiver for Cottage B on 06/29/2024. Staff F stated that Resident 1 came out of their room into the dining room and took utensils. Resident 1 left the dining room and went into their room. Staff F went into the laundry room and later discovered that Resident 1 was missing. No one was watching the other residents while they were in the laundry room. Staff F called 911. The Paramedics arrived, searched, and located the NR by the Fred Meyer store, about half a mile from the ALF. Staff F stated that if another caregiver needed help, they would call for help from another staff in another cottage. The caregiver coming to help will leave their assigned Cottage without a staff.

On 08/08/2024 at 11:20 AM, Staff K, Caregiver, stated that sometimes it would be challenging to watch their residents. Staff K stated that when they were with their residents for showers, it could take them 30 minutes and there would be no one to watch the other residents. Staff K stated that the Med Techs and Supervisors could not help because they would be doing their tasks.

This is a recurring citation previously cited on 12/21/2023.

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