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) 41742 (Completion Date 05/28/2024) and 32280 (Completion Date 12/21/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/28/2024 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-2450-1-b, 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,

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: THE COTTAGES AT MILL CREEK
Provider Type: Assisted Living Facility
License/Cert.#: 1977
Intake ID: 105301
Compliance Determination #: 32280
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 11/08/2023 through 12/21/2023
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) was found sitting on the ground at the parking lot of the Assisted Living Facility.

Investigation Methods:

Sample:	Total residents: 39 Resident sample size: 6 Closed records sample size: 1
Observations:	Identified resident Residents Activities Resident care equipment Resident rooms Resident to resident interactions Staff to resident interactions Door lock and alarm
Interviews:	Identified resident Nursing staff Residents Family members Maintenance staff
Record Reviews:	Incident investigation Facility policies Staff patterns Care plans Assessments Progress notes

Investigation Summary:
The Named Resident (NR) was cognitively impaired. The NR resides in a Memory care unit with a secured locked door and the NR was not allowed to go out without supervision. The Assisted Living Facility (ALF) failed to monitor, provide supervision and ensure the safety of the NR according to the Negotiated Service Plan. The NR was

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able to get out of the secured unit without the knowledge of the ALF staff assigned on the Cottages. It was determined that the NR was able to leave the Cottage passing through the front door unnoticed which was supposed to be equipped with automatic locks and alarms. Failed Practice was identified. A citation was issued for non compliance with WAC 388-78A-2450 (1) (a) (b) Staff.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: THE COTTAGES AT MILL CREEK
Provider Type: Assisted Living Facility
License/Cert.#: 1977
Intake ID: 104376
Compliance Determination #: 32280
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 11/08/2023 through 12/21/2023
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) was missing.

Investigation Methods:

Sample:	Total residents: 39 Resident sample size: 6 Closed records sample size: 1
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions Front door alarm and locking system
Interviews:	Identified resident Nursing staff Residents Family members Maintenance staff Executive Director
Record Reviews:	Incident investigation Facility policies Staff patterns care plans Assessment Progress notes

Investigation Summary:
The Assisted Living Facility (ALF) failed to monitor and ensure the whereabout of the Named Resident (NR) according to the Negotiated Service Plan. The NR was able to get out of the secured unit without the knowledge of the ALF staff. It was determined that the front door in the NR cottage does not lock and the Alarm do not work. Failed

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Practice was identified. A citation was issued for non compliance with WAC 388-78A-2450 (1) (a) (b) Staff.

Conclusion / Action:

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

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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 11/08/2023 and 11/27/2023 of:

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

This document references the following complaint number(s): 105521, 104376, 103729, 105257, 105301

The following sample was selected for review during the unannounced on-site visit: 6 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.

Kim Ripley
Residential Care Services

1/8/2024
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.

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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;

(b) Maintain the assisted living facility free of safety hazards; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to have enough staff to keep 2 of 2 residents (Resident 2 and 5) safe in the memory care cottages A and B. This failure resulted in Residents 2 and 5 leaving the ALF unnoticed from an unsecured door and placed all residents residing in the cottages at risk for leaving the ALF.

Findings included…

Review of the ALF's Disclosure of Services dated 03/2017 showed the ALF will have the following security services to help protect the residents with cognitive impairments and wandering behaviors:
- Restricted use of exit doors in a designated portion of the building designed to serve residents with dementia.

- Restricted use of exit doors throughout the building.

- Outside area available with restricted egress.

Resident 2

Resident 2 was admitted on [redacted]/2023 with multiple diagnoses including [redacted].

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Review of Negotiated Service Plan (NSP) dated 06/21/2023 showed Resident 2 ambulated independently regardless of any assistive device and had exit-seeking and wandering behaviors. Resident 2 required supervision and monitoring by the ALF staff 4x/hour. The ALF staff were to know the whereabouts of Resident 2. The NSP showed Resident 2 had a diagnosis of [redacted] requiring restricted egress. Resident 2 had a history of exit-seeking. The ALF staff were to ensure that all secure doors were closed and latched securely when entering or exiting the building.

Review of Incident investigation dated 11/06/2023 showed Resident 2 went missing and could not be located by the ALF staff in the ALF's vicinity after being last seen around 4:20 PM prompting the ALF staff to call 911. The ALF staff were told by 911 that Resident 2 was found by the Police and was at the hospital. The Police transported Resident 2 back to the ALF.

Review of Resident Roster dated 11/08/2023 showed Resident 2 resided in Cottage B.

On 11/08/2023 at 3:15 PM, Cottages A and B were observed to be in the same building but had separate secured and locked front entrances. The Cottages were equipped each with unlocked and unsecured back doors which lead to a common secured patio shared by Residents of Cottages A and B and were easily accessible by staff and residents.

On 11/08/2023 at 3:38 PM, Staff F, Caregiver/Med Tech, who worked evening shift in Cottage A, stated that Resident 2, who resides in Cottage B hangs out and is often in Cottage A.

On 11/08/2023 at 3:18 PM, Staff E, Med Tech/Caregiver stated that she saw Resident 2 at about 3:30 PM on 10/29/2023 when she went to Cottage A looking for bread.

On 11/27/2023 at 2:37 PM Staff G, Caregiver stated that there was a prior incident that happened on the same day 10/29/2023 where she found Resident 2 in the parking lot past 2:00 PM. Staff G stated that she checked the door in Cottage A. The door was not locked and there was no alarm sounding. Staff G stated that she called Staff C, Resident Care Manager and informed her about the incident and the broken front door in Cottage A.

On 11/08/2023 at 3:38 PM, Staff F, Caregiver/Med Tech, who worked evening shift in Cottage A on 10/29/2023, stated that he was informed by Staff E that the front door in Cottage A was broken and there was no alarm. Staff F stated that he tested the door in Cottage A and the door opened without an alarm. Staff F stated that because he was made aware that Resident 2 went out of the Cottage earlier on 10/29/2023 but they did not know how and with the door not alarming in Cottage A, he took the table and chairs and blocked the back door that connects Cottages A and B so that Resident 2 could not come to Cottage A. Staff F was assisting a resident in their room in cottage A. Staff F stated that he could not always keep an eye on the residents in his assigned Cottage especially if he was doing another task. Staff F did not call another staff to keep an eye on the residents in

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Cottage A because the other care staff were also busy. Staff F stated that he did not know that Resident 2 went out of the Cottage during his shift.

Resident 5

Resident 5 was admitted on [redacted]/2022 with multiple diagnosis including [redacted].

Review of Resident Roster dated 11/08/2023 showed Resident 5 resided in Cottage A.

Review of Negotiated Service Plan (NSP) dated 10/09/2023 showed Resident 5 uses a 4-wheeled walker and needed minimal assistance with ambulation. The NSP showed Resident 5 had a diagnosis of [redacted] and required restricted egress. The NSP showed staff were to monitor and supervise Resident 5 1-2x per shift.

Review of Incident report dated 11/05/2023 showed Resident 5 was found outside of the Cottage in the parking lot sitting on the ground near a car parked.

On 12/07/2023 at 3:13 PM, Resident 5 stated that they left the cottage by walking through the front door. Resident 5 stated that they pushed the front door and opened it. Resident 5 stated that there were no staff in the Cottage at that time to have stopped them from getting out. Resident 5 stated that they left to go walk outside.

On 12/07/2023 at 3:34 PM, Staff F, Caregiver/ Med Tech stated that on 11/05/2023 he left Cottage A to help another Care staff in Cottage B and that was the time Resident 5 went out. Staff F stated that he did not ask other staff to watch Cottage A while he went to help in Cottage B because everyone was busy. Staff F stated that he did not hear any alarm go off.

On 12/07/2023 at 3:22 PM, the front door in Cottage A was observed unlocked and when pushed, the alarm did not turn on. Staff F, Caregiver/MedTech and Staff H, Resident Care Coordinator came and tested the front door, and the door was not locking as well as the Alarm did no turn on.

On 12/07/2023 at 4:10 PM, Staff I, Maintenance Director came and fixed the door. Staff I

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stated that he had to reset the system for the door to automatically lock again.

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

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