STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

05/21/2025

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 letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 59964 (Completion Date 05/21/2025) and 56588 (Completion Date 04/08/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/21/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2250 Alteration of medications. The assisted living facility must generally provide medications in the form they are prescribed when administering medications or providing medication assistance to a resident. The assisted living facility may provide medications in an altered form consistent with the following:

(1) Alteration includes, but is not limited to, crushing tablets, cutting tablets in half, opening capsules, mixing powdered medications with foods or liquids, or mixing tablets or capsules with foods or liquids.

(2) Residents must be aware that the medication is being altered or added to their food.

(3) A pharmacist or other practitioner practicing within their scope of practice must determine that it is safe to alter a medication.

(4) If the medication is altered, documentation of the appropriateness of the alteration must be on the prescription container, or in the resident's record.

(5) Alteration of medications for self-administration with assistance is provided in accordance with chapter 246-888 WAC.

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-

2250 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(4) Take appropriate action in response to each resident's changing needs.

The Department staff who did the On Site verification:
Wesler Dumecquias, Community Complaint Investigator

If you have any questions, please contact me at (253)281-1245.

Sincerely,

Anthony Devito, Field Services Administrator
Region 2, Unit Z
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: 168524
Compliance Determination #: 56588
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 03/19/2025 through 04/08/2025
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) passed unexpectedly.

Investigation Methods:

Sample:	Total residents: 32 Resident sample size: 3 Closed records sample size: 2
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified staff Nursing staff Residents Family members Administrator
Record Reviews:	Medical records Hospital records Incident investigation Facility policies Assessments Care plan MAR progress notes PCP faxes/communications

Investigation Summary:
The Named Resident (NR) was found unresponsive by the Assisted Living Facility (ALF) staff in their apartment. The ALF was not able to obtain a new prescription and provide the NR's medications days before the NR passed away. The ALF administered the NR's medications crushed without a physicians' order. The ALF failed to assess and take action when the NR's condition deteriorated before they passed away. Failed practices were identified. Citations were issued for non

compliance with WAC 388- 78A-2250- Alteration of Medications; 388-78A-2210- Medication Services; and, WAC 388-78A-2120- Monitoring residents' well-being.

Conclusion / Action:

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

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20425 72nd Avenue S, Suite 400, Kent, WA 98032

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 03/19/2025 and 04/01/2025 of:

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

This document references the following complaint number(s): 168524

The following sample was selected for review during the unannounced on-site visit: 3 of 32 current residents and 2 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 Z
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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-2250 Alteration of medications. The assisted living facility must generally provide medications in the form they are prescribed when administering medications or providing medication assistance to a resident. The assisted living facility may provide medications in an altered form consistent with the following:

(1) Alteration includes, but is not limited to, crushing tablets, cutting tablets in half, opening capsules, mixing powdered medications with foods or liquids, or mixing tablets or capsules with foods or liquids.

(2) Residents must be aware that the medication is being altered or added to their food.

(3) A pharmacist or other practitioner practicing within their scope of practice must determine that it is safe to alter a medication.

(4) If the medication is altered, documentation of the appropriateness of the alteration must be on the prescription container, or in the resident's record.

(5) Alteration of medications for self-administration with assistance is provided in accordance with chapter 246-888 WAC.

This requirement was not met as evidenced by:

Based on interview and records review, the Assisted Living Facility (ALF) failed to provide the medication in the prescribed form for 1 of 2 Residents, (Resident 1) when staff gave the medications crushed without an order. The failure resulted in Resident 1 receiving their medications in an altered form without physician order and placed Resident 1 at risk for increased possibility of medication interaction and less effectivity.

Findings included…

Resident 1

Review of Face sheet showed Resident 1 moved into the ALF on [redacted]/2025 with multiple diagnoses including [redacted].

Review of Service plan dated 12/20/2024 showed resident 1 was on medication assistance. The ALF staff would administer all medications as per physician order.

Review of Medication Administration Record (MAR) dated February 2025 showed Resident 1 had the following prescribed medications:
a. Amlodipine Tablet (tab) 10 milligrams (mg) one tab daily (by mouth) as calcium channel blocker;
b. Aspirin 81 mg tab chewable one tab daily (by mouth) as analgesic (Prophylactic);
c. Calcium-Cit/Vit D3 315mg/200units (u) tablet two tablets daily (by mouth) for antacid(supplement);
d. Carvedilol 6.2 mg tab two times daily (by mouth) as beta blocker.
e. Melatonin tab 1 mg, one tablet at bedtime (by mouth) as sleep aid.
f. Acetaminophen 325 mg tab, two tab by mouth as needed for pain.
The MAR did not show an instruction to crush and mix the medication with liquids or food.

Review of 'AFTER VISIT SUMMARY" dated [redacted]/2025 showed there was no order to crush and mix the medication with liquids or foods or the reason for altering the form of the medication before administering.

On 03/19/2025 at 4:25 PM, Staff D, Medication Technician (Med Tech), stated that they had been crushing Resident 1's medication and mixing it with pudding. Staff D stated that there was no physician order to crush and mix the medication with food. Staff D stated that the Resident Care Coordinator (RCC) at that time instructed them to crush the medications for Resident 1.

On 03/19/2025 at 4:41 PM, Staff E, Med Tech stated that they crushed the medications and mixed it with pudding, ice cream or shakes before giving it to Resident 1. Staff E stated that there was no physician order to crush the mediations. Staff E stated that Staff B, Resident coordinator, told them to crush Resident 1 medications before they were administered them. Staff E stated that they did not inform the resident that they were crushing their medication and mixing it with food because Resident 1 would not understand due to dementia.

On 03/19/2025 at 5:00 PM, Staff B stated that they told the MTs to crush the medications and mix it with pudding before giving it to Resident 1. Staff B stated that they did not have a physician order, but they followed what the hospital told them

about how Resident 1 takes their medications.

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-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living facility (ALF) failed to ensure 1 of 2 residents (Resident 1) received all their medications as prescribed. This failure resulted in Resident 1 not receiving their prescribed medications. The failure resulted in Resident 1 not receiving all their medications and placed them at risk for health complications.

Findings included…

Review of the ALF's current policy titled "Medication Services" undated showed the ALF would assist and/or administer prescription and over-the-counter medications as allowed by state statute/regulations and will maintain records of such assistance/administration.

Resident 1

Review of Face sheet showed Resident 1 was moved into the ALF on [redacted]/2025 with

multiple diagnoses including [redacted].

Review of Service plan dated 12/20/2024 showed resident 1 was on medication assistance. The ALF staff would administer all medications as per physician order.

Review of Medication Administration Record (MAR) dated February 2025 showed Resident 1 had the following prescribed medications:
a. Amlodipine Tablet (tab) 10 milligrams (mg) one tab daily (by mouth) as calcium channel blocker;
b. Aspirin 81 mg tab chewable one tab daily (by mouth) as analgesic (Prophylactic);
c. Calcium-Cit/Vit D3 315mg/200units (u) tablet two tablets daily (by mouth) for antacid(supplement);
d. Carvedilol 6.2 mg tab two times daily (by mouth) as beta blocker.
e. Melatonin tab 1 mg, one tablet at bedtime (by mouth) as sleep aid.
f. Acetaminophen 325 mg tab, two tab by mouth as needed for pain.

Review of the MAR dated February 2025 showed Resident 1 did not receive their Carvedilol and Melatonin from 02/19/2025 through [redacted]/2025. The record showed Amlodipine, Aspirin and the Cal-cit/vit D3 supplement ran out on 02/20/2025 through [redacted]/2025 when Resident 1 passed away.

On 03/19/2025 at 3:42 PM, Staff B, Resident Care Director, stated that Resident 1 used their facility pharmacy. Staff B stated that the ALF managed Resident 1's medications and would order and obtain the medications from their facility pharmacy. Staff B stated that they did not have a current Primary Care Physician (PCP) to get the medication orders from. Staff B stated that the previous Resident Care Coordinator (RCC), had worked to get Resident 1 a new PCP since on [redacted]/2025. Staff B stated that they only realized around [redacted]/2025, a week from [redacted]/2025 that Resident 1's listed PCP was not correct.

Review of a Fax Cover Sheet dated 02/01/2025 showed Staff B sent Resident 1's medical records to enroll with a new PCP.

On 03/28/2025 at 8:21 AM, Collateral Contact 4 (CC4), Triage Nurse, stated that the ALF faxed their office on 02/01/2025 an enrollment packet to admit Resident 1 into their care and be assigned a PCP. CC4 stated that the ALF faxed other records on 02/12/2025 and 02/21/2025 as part of the admission process. CC4 stated that they told the ALF that they could not prescribe medications until Resident 1 was admitted for services by their team. CC4 stated that they reminded the ALF to either bring Resident 1 to an urgent care or emergency room if they could not get refills. CC4 stated that the ALF completed the enrollment on [redacted]/2025 and on the same day, the ALF informed them that Resident 1 passed away. CC4 stated that even if the enrollment was completed, their office had to schedule an appointment to see Resident 1 before they could write orders.

On 03/28/2025 at 9:18 AM, Staff F, Regional Nurse, stated that when a resident would run out of their medications, they would put the resident on alert charting for 72 hours, follow up with the facility's Pharmacy and the residents' PCP. Staff F stated they do not know what the protocol and was unsure if sending a resident to an urgent care would be an option.

Review of Department of Social Health and Services (DSHS), Service Summary Assessment dated 01/23/2025 showed Collateral Contact 1, was listed as the Primary Care Physician for Resident 1.

On 03/31/2025 at 9:22 PM, Collateral Contact 3 (CC3), Guardian stated that the last PCP prior to hospitalization was CC1. CC3 stated that the ALF would transition Resident 1 to another PCP when they moved to the ALF. CC3 stated that they did not know if the ALF notified the office of CC1.

On 03/31/2025 at 11:31 PM, Collateral Contact 5 (CC5), Clinic manager, stated that Resident 1 was a client of CC1. CC5 stated that CC1 refilled Resident 1's medications on 12/10/2024. CC5 stated that there was no communication from the ALF for them to refill or know that Resident 1 was living in the ALF.

On 03/31/2025 at 1:00 PM, Staff B stated that they did not know that CC1 was listed as the PCP for Resident 1 in the DSHS, Service Summary Assessment.

This is a recurring citation previously cited on 04/28/2022 and 03/19/2024.

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-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and records review, the Assisted Living Facility (ALF) failed to evaluate and take action for 1 of 2 residents (Resident 1) who had a deterioration in condition. These failures resulted in unmet care needs and placed Resident 1 at risk for health complications.

Review of the ALF's policy titled, "ASSESSMENT-ONGOING Focused Assessment: dated 10/01/2020 showed it was the policy of the ALF to complete an assessment specifically focused on a resident's identified problems and related issues which were: (a) Consistent with the resident's change of condition as specified in WAC 388 78A 2120; (b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences".

Resident 1

Review of Face sheet showed Resident 1 was moved into the ALF on [redacted]/2025 with multiple diagnoses including [redacted].

Review of an Assessment dated 12/20/2024 showed resident 1 was on a regular diet, regular texture and thin liquid with no restrictions in their diet. The assessment did not mention that Resident 1 preferred or drank shakes.

On 03/19/2025 at 3:20 PM, Staff B, Residential Care Coordinator, stated that Resident 1 drank shakes 3x daily and did not like to eat the food they ALF served but would take few bites. Staff B stated that they informed and coordinated with their Licensed Nurse at that time that Resident was no longer eating and only drank shakes. Staff B stated that they did not inform any Primary Care Physician (PCP) because Resident 1 did not currently have a PCP.

On 03/19/2025 at 4:20 PM, Staff C, Caregiver, stated that Resident 1 would only drank shakes. Staff C stated that Resident 1's shakes intake had declined. Staff C stated that they let Staff B, and the Licensed Nurse know about the decline in nutritional intake.

On 03/19/2025 at 4:41 PM Staff E, Medication Technician (Med Tech), stated that Resident 1 was eating a little solid food and then gradually declined in their food intake.

Staff E stated that Resident 1 drank shakes following the decline in solid food intake. Staff E stated that they observed Resident 1 was weaker and had rapid breathing a day before they passed away. Staff E stated that they did not report the change.

Review of the Service plan dated [redacted]/2024 did not show Resident 1 was not eating solid food and had only drank shakes.

Review of Progress notes dated 02/23/2025 showed Resident 1 became weaker and breathing more rapid.

On 03/31/2025 at 1:00 PM, Staff B stated that they were not made aware by staff that Resident 1 had become weaker, and breathing was more rapid a day before they passed away.

On 03/31/2025 at 1:24 PM, Staff G, Executive Director, stated that in cases when a resident was observed becoming weaker and had rapid heart rate, the ALF staff would send the Resident to an urgent care or Emergency hospital.

This is a recurring citation previously cited on 11/29/2022.

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