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

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) 64226 (Completion Date 08/15/2025) and 62656 (Completion Date 07/24/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/15/2025 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-2371-3, WAC 388-78A-2371-2, WAC 388-78A-2371-1

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

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 2, Unit D
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: 184267
Compliance Determination #: 62656
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 07/16/2025 through 07/24/2025
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) eloped from the Assisted Living Facility (ALF).

Investigation Methods:

Sample:	Total residents: 37 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Activities Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members Maintenance staff
Record Reviews:	Incident investigation Facility policies care plans- Temporary care plan Assessments- including DSHS assessment Progress notes Staffing

Investigation Summary:
The ALF investigated the second incident and determined the NR forcefully opened their window and was able to get out. The ALF noticed the NR missing. The ALF staff followed their protocol and was able to locate the NR standing by the roadside near the ALF. The NR was brought back by the ALF staff and placed on alert charting and monitoring. The ALF followed the care plan. All parties were notified. The ALF failed to investigate, determine the circumstances and document their findings, and institute preventative measures to prevent a similar incident from happening for the same NR. Failed practice was identified. A citation was issued for noncompliance

with WAC 388-78A-2371 (10(2)(3)- Investigations.

Conclusion / Action:

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

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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 07/16/2025 of:

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

This document references the following complaint number(s): 184267, 184290

The following sample was selected for review during the unannounced on-site visit: 3 of 37 current residents and 0 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

Statement of Deficiencies	License #: 1977	Compliance Determination # 62656
Plan of Correction	THE COTTAGES AT MILL CREEK	Completion Date
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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.

Anthony Davila
Residential Care Services

7/29/2025
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.

BERYL MURUKI
Administrator (or Representative)

7/30/2025
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;

(2) Determine the circumstances of the event;

(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 interviews, and record review, the Assisted Living Facility (ALF) failed to investigate, and institute preventative measures when 1 of 1 Resident (Resident 1) left the ALF by climbing through the window. This failure placed Resident 1 at risk for harm, abuse and neglect.

Findings included...

Review of the ALF's "ELOPMENT- Missing resident" policy dated 10/07/2020 showed elopement was defined as the process of leaving protected and safe surroundings with no focused designation or the inability to return safely after exiting the facility. The Licensed Nurse of the Executive Director would conduct a preliminary investigation to determine means of exit, secure any unsecured areas and implement any emergent measures to keep the residents safe.

Review of an undated Face sheet showed Resident 1 was admitted on [redacted]/2025 with multiple diagnoses including [redacted].

On 07/17/2025 at 3:36 PM, Collateral Contact 1 (CC1) stated they were informed by the ALF staff that Resident 1 climbed up and was able to get out through the Cottage window. CC1 stated that this occurred two times on 06/07/2025 and 06/23/2025.

Review of progress notes dated 06/07/2025 showed Resident 1 exited their apartment in Cottage D on 06/07/2025 by climbing out through their window, proceeded through the ALF parking lot and went to the front door of Cottage D.

Review of incident report dated 06/23/2025 showed Resident 1 climbed out of another resident's window and was found standing by the roadside near the ALF.

On 07/16/2025 at 3:04 PM, Staff B, House Manager stated that they did not investigate the incident on 06/07/2025 because Staff C, Corporate Administrator, instructed them not to report the incident to the Department of Social Health and Services. Staff B stated it was their understanding that although the resident climbed through their window, they did not consider the incident an elopement because the residents was still within the perimeter of the ALF.

Review of Temporary Service Plan dated 06/07/2025 to 06/09/2025 showed Resident 1 was to be checked on every 30 minutes due to the elopement.

On 07/23/2025 at 4:14 PM, Staff H, Resident Care Coordinator stated that they would normally investigate and report this type of incident. Staff H stated they did not think that an investigation was carried out. Staff H stated they did not do an investigation and would not know if Staff B conducted one.

Review of progress notes dated 06/07/2025 showed the incident where Resident 1 exited their apartment. There were no records or documentation to show that an investigation was conducted.

Statement of Deficiencies	License #: 1977	Compliance Determination # 62656
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Page 4 of 4	Licensee: MILL CREEK SPECIAL CARE COMMUNITY LLC	07/24/2025

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) 8/13/2025 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) BERYL MURIUKI Date 7/30/2025