STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 78087 (Completion Date 05/28/2026) and 74767 (Completion Date 03/31/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/28/2026 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-2210-1-b, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3

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

If you have any questions, please contact me at (206)305-3489.

Sincerely,

Jim Sherman

James Sherman, 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: 215974
Compliance Determination #: 74767
Region/Unit #: RCS Region 2 / Unit D
Investigator: Wesler Dumecquias
Investigation Date(s): 03/24/2026 through 03/31/2026
Complainant Contact Date(s): 03/18/2026

Allegation(s):

1. The Named Resident was observed to be asleep at the dining table with their face on their food.
2. The facility staff compelled and grabbed the NR's arms while they were seated for their meal to measure their weight, which led to the NR feeling upset and getting agitated.
3. The facility staff attempted to place the NR's dentures despite the NR's refusal and requests for the staff to stop.
4. The facility staff provided medication for agitation without obtaining permission from the hospice nurse.

Investigation Methods:

Sample:	Total residents: 35 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Activities Resident care equipment Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Executive Director Collateral contacts
Record Reviews:	Incident investigation/witness statements Grievance log Facility policies care plans assessments

medication administration record
hospice notes
progress notes

Investigation Summary:

1. The Named Resident (NR) was primarily noted to take naps during the daytime. Facility staff observed that the NR would sleep for 2-3 hours and then be awake, walking and being observed in the dining area during nighttime. The facility communicated with the NR's family regarding this behavior and coordinated with hospice services to address the concern. The staff continued to monitor the NR. No failed practice identified.
2. The facility conducted an investigation into the incident. The family of the NR involved was present and assisted the staff in encouraging the NR. With the NR's family help, the staff was able to have the NR sit at the weighing scale. Initially the NR was unwilling to place their foot on the weighing scale footrest, but the NR's family was able to help and encouraged the NR to get weighed. The family raised a question regarding the necessity of the need to weigh the NR which led the facility to request hospice services to discontinue the monthly weight monitoring. The task was then discontinued. There were no similar incidents observed during the visit. The facility provided retraining for the staff to reinforce residents' rights and continued to monitor the NR's behavior.
3. The facility conducted an investigation into the incident. The staff member involved denied the allegation and indicated that they ceased attempts to have the NR wear their dentures upon the request of the NR's family. There was insufficient evidence to support the claims. The facility continued to monitor the NR's behavior and continued to encouraged the NR's participation in activities of daily living. No failed practice was identified.
4. The facility staff did not follow the medication order as they did not contact the hospice services before administering a medication for the resident's behavior as prescribed. The facility did not investigate the medication error. Failed practices were identified and citations were issued in a Statement of Deficiencies.

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 03/24/2026 of:

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

This document references the following complaint number(s): 215974

The following sample was selected for review during the unannounced on-site visit: 3 of 35 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

Statement of Deficiencies	License #: 1977	Compliance Determination # 74767
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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.

Residential Care Services — Date: 04/09/2026

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 MURIUKI — Administrator (or Representative) — Date: 04/09/2026

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to follow the medication order prescribed by hospice for 1 of 1 resident (Resident 1) who received medication administration services by facility staff. This failure placed Resident 1 at risk of harm due to a medication error.

Findings included...

Record review of a face sheet showed Resident 1 was admitted on [redacted], 2021, with multiple diagnoses including [redacted].

Record review of Resident 1's Service Plan (SP) dated January 08, 2026, showed Resident 1 was admitted to Hospice services on December 29, 2025. The SP showed Resident 1 received assistance with medication administration under nurse delegation from the facility staff.

A review of Resident 1's Medication Administration Record (MAR) dated March 2026 indicated that Resident 1 was prescribed Phenobarbital 60 Milligrams (MG) on

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 _____

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Administrator (or Representative) _____ Date _____

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A review of Resident 1's Medication Administration Record (MAR) dated March 2026 indicated that Resident 1 was prescribed Phenobarbital 60 Milligrams (MG) on

December 27, 2025, to be administered one tablet by mouth every four hours as needed for terminal agitation, with staff required to contact the hospice provider before administration. The MAR indicated that Resident 1 received the medication on March 11, 2026, at 10:07 AM, administered by Staff F, Medication Technician.

In interview on March 24, 2026, at 2:05 PM, Staff F confirmed that they administered phenobarbital to Resident 1 due to severe agitation. Staff F stated that they contacted hospice prior to administering the medication but did not document the details of the call.

In interview on March 24, 2026, at 2:12 PM, Staff A, the Executive Director, stated that Staff F administered the medication to Resident 1 without first consulting the hospice provider and then reached out to hospice afterward.

In an interview on March 26, 2026, at 2:00 PM, Collateral Contact 1 (CC1) stated that they did not receive any communication from the facility prior to the administration of the phenobarbital to Resident 1. CC1 stated that the facility not only failed to call them before administering the medication but also did not inform them afterwards. Upon discovering that the facility had given the medication without notification, CC1 requested that the medication be discontinued.

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) 05/15/2026 .

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

Beryl Mucci — Administrator (or Representative)

04/09/2026 — 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:

December 27, 2025, to be administered one tablet by mouth every four hours as needed for terminal agitation, with staff required to contact the hospice provider before administration. The MAR indicated that Resident 1 received the medication on March 11, 2026, at 10:07 AM, administered by Staff F, Medication Technician.

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In interview on March 24, 2026, at 2:12 PM, Staff A, the Executive Director, stated that Staff F administered the medication to Resident 1 without first consulting the hospice provider and then reached out to hospice afterward.

In an interview on March 26, 2026, at 2:00 PM, Collateral Contact 1 (CC1) stated that they did not receive any communication from the facility prior to the administration of the phenobarbital to Resident 1. CC1 stated that the facility not only failed to call them before administering the medication but also did not inform them afterwards. Upon discovering that the facility had given the medication without notification, CC1 requested that the medication be discontinued.

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(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 interview and record review, the Assisted Living Facility (ALF) failed to investigate, determine the circumstances, and institute preventative measures when a staff member administered medication without following the prescribed orders for 1 of 1 resident (Resident 1). This failure resulted in the ALF not being able to determine the circumstances, rule out abuse or neglect or identify preventative measures for Resident 1 and placed the resident at risk of future medication errors.

Findings included…

Record review of a face sheet showed Resident 1 was admitted on [redacted], 2021, with multiple diagnoses including [redacted].

A review of Resident 1's Medication Administration Record (MAR) dated March 2026 indicated that Resident 1 was prescribed Phenobarbital 60 Milligrams (MG) by hospice on December 27, 2025, to be administered one tablet by mouth every four hours as needed for terminal agitation, with staff required to contact the hospice provider before administration. The MAR indicated that Resident 1 received the medication on March 11, 2026, at 10:07 AM, administered by Staff F, Medication Technician.

In interview on March 24, 2026, at 2:05 PM, Staff F confirmed that they administered phenobarbital to Resident 1 due to severe agitation.

In interview on March 24, 2026, at 2:12 PM, Staff A, the Executive Director, stated that Staff F administered the medication to Resident 1 without first consulting the hospice provider and then reached out to hospice afterward.

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In interview on March 26, 2026, at 4:02 PM, Staff A stated that they do not have specific policy regarding medication errors. Staff A stated that they follow the Assisted Living Facility guidebook, published by the department, dated February 2018 (This document contains guidelines for the protection of assisted living facilities residents along with guidelines for preventing, investigating, determining, and reporting incidents of resident abuse, neglect, abandonment, injuries of unknown source, or personal and/or financial exploitation, in assisted living facilities, including reporting reasonable suspicion of a crime in a Long-Term Care (LTC) facility) when investigating medication errors.) Staff A stated that typically, they would complete an incident report, inform the doctor, the nurse, and the family. Staff A also stated that an investigation would be conducted, and the resident would be monitored. However, Staff A stated that no incident report and no

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investigation was conducted for the medication error. Staff A stated that they started an incident report and investigation only after the department investigator brought the issue to their attention upon arrival (on-site visit) at the facility on March 24, 2026, 13 days after the incident.

This is a recurring deficiency previously cited on 07/24/2025 and 03/13/2024.

Plan/Attestation Statement

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

Administrator (or Representative) 04/09/2026 Date

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Administrator (or Representative) Date