



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) 82814 (Completion Date 08/26/2026) and 78426 (Completion Date 06/25/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/26/2026 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-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 (206)305-3489.

Sincerely,

James Sherman, Field Manager
Region 2, Unit D
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.



Residential Care Services Investigation Summary Report

Provider/Facility: THE COTTAGES AT MILL CREEK **Provider Type:** Assisted Living Facility

License/Cert.#: 1977

Intake ID: 225554

Compliance Determination #: 78426

Region/Unit #: RCS Region 2 / Unit D

Investigator: Wesler Dumecquias

Investigation Date(s): 06/03/2026 through 06/25/2026

Complainant Contact Date(s): 06/18/2026

Allegation(s):

The Named Resident (NR) was found by the local law enforcement walking along the highway.

Investigation Methods:

Sample: Total residents: 36
Resident sample size: 3
Closed records sample size: 0

Observations: Identified resident
Residents
Activities
Dining
Resident care equipment
Resident rooms
windows locks and alarms
Door alarms
activities

Interviews: Identified resident
Nursing staff
Family members
Collateral contacts

Record Reviews: Incident investigation
Facility policies
Staff patterns
care plans
Assessments
Progress notes
Investigations
Calendar of activities

Investigation Summary:

The facility did not ensure that a staff member was present in one Cottage to oversee and monitor the residents, including the NR who had a history of elopement

and exhibited exit-seeking behaviors. The NR ultimately left the facility through the window of their apartment and went missing for approximately two hours. The police found the NR on a busy highway near the facility. The facility also did not secure their windows. Failed practice was identified and a citation was issued. See Statement of Deficiencies report.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



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Statement of Deficiencies	License #: 1977	Compliance Determination # 78426
Plan of Correction	THE COTTAGES AT MILL CREEK	Completion Date
Page 1 of 5	Licensee: MILL CREEK SPECIAL CARE COMMUNITY LLC	06/25/2026

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 06/03/2026 of:

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

This document references the following complaint number(s): 225554, 227534

The following sample was selected for review during the unannounced on-site visit: 3 of 36 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

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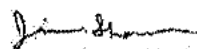
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Statement of Deficiencies	License #: 1977	Compliance Determination # 78426
Plan of Correction	THE COTTAGES AT MILL CREEK	Completion Date
Page 2 of 5	Licensee: MILL CREEK SPECIAL CARE COMMUNITY LLC	06/25/2026

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

06/30/2026

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)

07/02/2026
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 their 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 ensure a staff was available in one secured memory care cottage to monitor and supervise 1 of 1 resident (Resident 1) for safety. This failure contributed to Resident 1 exiting the cottage, unnoticed by staff during the night, and placed Resident 1 at risk of harm.

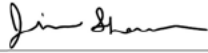
Findings included...

A review of the ALF's undated "Elopement- Missing Resident Policy" showed that 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.

Review of a face sheet showed Resident 1 moved to the facility on [REDACTED] /2026 with multiple diagnoses including [REDACTED].

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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

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Review of a face sheet showed Resident 1 moved to the facility on [REDACTED]/2026 with multiple diagnoses including [REDACTED]

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Review of Resident 1's Service Plan (SP) dated 03/05/2026 and 04/21/2026 showed Resident 1 had a diagnosis of [REDACTED] that required restricted egress. Access to the community at large without supervision would put residents at risk of harm, abuse, neglect, exploitation, or personal injury. The SP showed Resident 1 had wandering and exit seeking behavior. Additionally, the SP showed a history of Resident 1 leaving their previous home and getting lost. The SP showed the facility staff would ensure Resident 1's safety, monitoring or supervision.

Review of the ALF's elopement incident report dated 05/22/2026 showed Resident 1 eloped on 05/22/2026 at 9:03 PM and was brought back to the facility by the Police and Resident 1's family.

Review of Department records, dated 05/22/2026, showed Resident 1 was found by the Police walking along Bothell Everett Highway about .4 miles from the facility.

Observation on 06/03/2026 at 1:40 PM, showed the secured memory care facility with four cottages and fenced outdoor area located directly adjacent to a street and nearby four lane heavily traveled state highway with access to the Interstate highway.

During an interview on 06/03/2026 at 1:49 PM, Staff B, Caregiver, stated that Resident 1 tends to wander around the facility and frequently expressed a desire to go home or outside to make a purchase of something.

During an interview on 06/03/2026 at 1:55 PM, Resident 1 stated that they exited their apartment through the window. Resident 1 stated they did not see any "worker" (Staff) and no one saw them leaving. Resident 1 stated they could not figure out how to get back to the facility.

During an interview on 06/18/2026 at 2:12 PM, Staff A, Resident Care Coordinator-Designee, stated that they were uncertain regarding their responsibility of checking the windows to confirm that the locks were functioning and that the windows were secured. Staff A stated that they were uncertain if there was a protocol to ensure the window alarms were working. Staff A stated that to ensure residents were monitored

and supervised, when a staff takes a break or assists another staff in a different cottage, additional staff were required to be present in that cottage to oversee the residents there.

During an interview on 06/03/2026, at 2:54 PM, Staff D, a Caregiver and Medication Technician (MT), stated that they were assigned to Resident 1's Cottage (Cottage C) at the time Resident 1 went missing. Staff D stated they simultaneously served as the MT for the adjoining Cottage D. While administering medications in Cottage D, Staff D requested Staff G, a caregiver assigned to Cottage D, to monitor the residents in Cottage C. After completing the medication administration in Cottage D, Staff D switched places with Staff G. Staff G returned to their assigned Cottage while Staff D went back to Cottage C. Staff D stated that around 8:30 PM, they took a break and asked Staff G to supervise both Cottages C and D during their absence. Upon returning from the break, Staff D found that Staff G needed help to change and put three residents to bed who required two-person assistance in Cottage D. Staff D stated that they left Cottage C to assist Staff G and stated that there was no one assigned to supervise Cottage C at that time since only four staff members were assigned across all four cottages, leaving no additional staff available. Staff D stated that they did not know how Resident 1 got out and they learned of the incident when the Police returned Resident 1 back to the facility. Staff D stated that the Police showed them Resident 1's window was broken. Staff D stated that Resident 1's window did not have a window stopper and that it was only fixed after the incident.

During an interview on 06/03/2026 at 3:15 PM, Staff E, Caregiver, stated that they worked the evening shift on 05/22/2026 when the incident happened, where they were assigned as a caregiver for Cottage B and as a MT for Cottages A and B. Staff E stated that there were four staff members present for the evening shift, with one assigned to each Cottage. Additionally, two of the staff members served as MTs and assigned to two cottages each. Staff E stated that if a resident required assistance from two staff members in either Cottage, both staff would need to respond, which would result in one Cottage being left without staff.

This is a recurring citation previously cited on 12/21/2023 and 08/23/2024.

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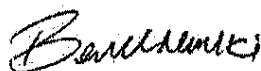
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Page 5 of 5	Licensee: MILL CREEK SPECIAL CARE COMMUNITY LLC	06/25/2026

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) 08/09/2026.

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

Administrator (or Representative)

Date 07/02/2026

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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