STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
***PO Box 99250, Lakewood, WA 98496***

Milton Meridian LLC
The Meridian at Stone Creek
1111 S 376th St
Milton, WA 98354

RE: The Meridian at Stone Creek License # 2365

Dear Administrator:

This letter addresses Compliance Determination(s) 83593 (Completion Date 09/10/2026) and 76661 (Completion Date 07/22/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/10/2026 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-2240, WAC 388-78A-2640-1-a, WAC 388-78A-2350-1, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-2-a, WAC 388-78A-2140-5, WAC 388-78A-2420-3

The Department staff who did the on-site verification:
Woodetta Maulana,

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit D
Residential Care Services

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|---|---|---|
| Statement of Deficiencies | License #: 2365 | Compliance Determination # 76661 |
| Plan of Correction | The Meridian at Stone Creek | Completion Date |
| Page 1 of 11 | Licensee: Milton Meridian LLC | 07/22/2026 |

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 04/29/2026 of:

The Meridian at Stone Creek
1111 S 376th St
Milton, WA 98354

This document references the following complaint number(s): 221822, 221766, 221614, 221321, 229205, 226279, 224347

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

The department staff that investigated the Assisted Living Facility:

Woodetta Maulana,

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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

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.

Laurie Anderson
Residential Care Services

07/31/2026
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.

Rachel Baird
Administrator (or Representative)

8/7/2026
Date

**WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.**

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 3 residents (Resident 1, Resident 2, and Resident 3) medications were obtained in a timely manner. This failure placed Resident 1, Resident 2, and Resident 3 at risk for worsening health conditions related to missed medications.

Findings included...

RESIDENT 1
Review of Resident 1's records showed Resident 1 admitted to the facility on [redacted]/2026 and required assistance with medications.

Review of Resident 1's May 2026 medication administration record (MAR) showed Resident 1 missed their prescribed medications from 05/02/2026 through 05/11/2026. The MAR showed documentation that the medications were not in the facility.

RESIDENT 2
Review of Resident 2's June 2026 MAR showed Resident 2 required medication assistance. The MAR showed Resident 2 missed their prescribed medications from 06/23/2026 through 06/30/2026. The MAR showed documentation that the medications were not in the facility.

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RESIDENT 3
Review of Resident 3's records showed Resident 3 admitted to the facility on [redacted]/2026 and required assistance with medications. The records showed Resident 3 was evaluated at the hospital on 07/03/2026 for open areas on both feet. Resident 3 returned to the facility on 07/03/2026[LA2.1] with orders for clotrimazole 1% cream (topical antifungal medication), applied topically to the affected areas twice daily, and cephalexin (oral antibiotic), 500 milligrams, one capsule by mouth four times daily for seven days.

Review of Resident 3's July 2026 MAR showed the clotrimazole cream was first administered on 07/06/2026, three days after Resident 3 returned from the hospital. As of 07/15/2026, the MAR showed no documentation the Resident 3 started on the cephalexin. The MAR showed documentation that the medication was not in the facility.

During an interview on 07/14/2026 at 12:23 p.m., Staff B, the Resident Care Director, stated that Resident 1's medications were later found in the office. During the same interview, Staff A, the Executive Director, and Staff B stated that the facility used a pharmacy that did not deliver Residents 2 and Resident 3's medication in a timely manner.

**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 Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 9/5/2026.

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

Rachel Bond — Administrator (or Representative)

8/7/2026 — Date

**WAC 388-78A-2640 Reporting significant change in a resident's condition.**

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

**This requirement was not met as evidenced by:**

Based on record review and interview, the facility failed to ensure 1 of 3 residents (Resident 4) significant change in condition was reported to the appropriate individuals

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as soon as possible. This failure placed Resident 4 at risk of a decline in their health due to delayed assessment and treatment related to their change of condition.

Findings included...

Review of the facility's policy "wound and skin care", dated 12/13/2024, directed staff to respond appropriately to wound or skin integrity issues". The policy directed the Resident Care Director, Staff B, or designee to "notify the physician and family immediately". The policy further directed staff to "request home health or wound-care services from the physician".

Record review showed that on 05/19/2026, the facility faxed Resident 4's physician and documented, "resident above has a water-like blister on their upper bottom. Please advise. I can send a pic if you would like to see it." The physician responded, "Yes, please send a pic. How long has the blister been present"?

Review of Resident 4's progress note, dated 05/22/2026, documented "the blister at the resident's coccyx is now popped and open". The record contained no evidence the facility sent the requested photograph, informed the physician how long the blister had been present, or otherwise followed up regarding Resident 4's change in condition.

During an interview on 07/15/2026, at 9:00 AM, Staff C, Medication Technician, stated that the area was present for approximately one to two weeks before Resident 4 passed away on [redacted]/2026. Staff C described the area as approximately the size of a fingertip, open in the center, and surrounded by blisters. Staff C stated that they notified Staff B, the Resident Care Director, when they became aware of the open area.

During an interview on 07/15/2026 at 9:10 AM, Staff D, Caregiver, stated that the area was present for approximately two weeks and described it as open, bleeding and "bad". Staff D stated that they notified a medication technician on the day they noticed the open area.

During an interview on 07/15/2026 at 9:15 AM, Staff E, Caregiver, described the area as approximately the size of a fingertip, open in the center, surrounded by blisters. Staff E stated the medication technician was aware of the area because the medication technician assisted with Resident 4's care.

Review of the department records showed on 05/28/2026 at 4:17 PM, during an interview with Staff A, Executive Director, and Staff B, Resident Care Director stated that Staff B became aware of the open area around Monday 05/25/2026.

During an interview on 07/14/2026 at 12:23 PM, Staff B stated that they became aware

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of the open area on the morning of [redacted]/2026, the day Resident 4 passed away. During the same interview, Staff A stated that they were not aware Resident 4 had any skin concerns.

**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) 8/7/2026 Date

**WAC 388-78A-2350 Coordination of health care services.**

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

**This requirement was not met as evidenced by:**

Based on record review and interview, the facility failed to coordinate necessary wound care services with an external health care provider for 1 of 3 residents (Resident 4). This failure placed Resident 4 at risk of a decline in their health due to delayed assessment and treatment related to their change of condition.

Findings included...

Review of the facility's policy "wound and skin care", dated 12/13/2024, directed staff to respond appropriately to wound or skin integrity issues". The policy directed the Resident Care Director (Staff B) or designee to "notify the physician and family immediately". The policy further directed staff to "request home health or wound-care services from the physician".

Record review showed that on 05/19/2026, the facility faxed Resident 4's physician and documented, "resident above has a water-like blister on their upper bottom. Please advise. I can send a pic if you would like to see it." The physician responded, "Yes, please send a pic. How long has the blister been present"?

Review of Resident 4's progress note, dated 05/22/2026, documented "the blister at the

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resident's coccyx is now popped and open". The record contained no evidence that the facility informed the physician of this change, responded to the physician's request for additional information, or coordinated further assessment and treatment.

During interviews on 07/15/2026, Staff C at 9:00 AM, Staff D at 9:10 AM and Staff E at 9:15 AM stated they were aware of Resident 4's open coccyx area. Staff C and Staff E described an open center surrounded by blisters, while Staff D described the area as open, bleeding, and "bad." Staff reported the area had been present for approximately one to two weeks. Staff D and E notified a medication technician, and Staff C notified Staff B, the Resident Care Director.

This is a repeat deficiency previously cited on 05/16/2025 for subsection (1).

**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 Meridian at Stone Creek is or will be in compliance with this law and / or regulation on (Date) 9/15/2026.

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

Administrator (or Representative) — Date 8/7/2026

**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 interview and record review, the facility failed to investigate, determine the circumstances surrounding an injury of unknown origin, and rule out abuse or neglect for 1 of 1 resident (Resident 5). This failure endangered Resident 1's safety and placed them at risk of further physical or emotional harm.

Findings included...

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Review of the facility's "Internal Incident Report," dated 04/17/2026, documented that care staff notified a nurse of an old skin tear measuring approximately 10 centimeters. The incident report referenced a fall that occurred on 04/10/2026, and identified the injury associated with that fall as unknown.

Review of the facility's "Internal Incident Report," dated 04/22/2026, documented that Staff B, Resident Care Director, was informed of a large area of discoloration on Resident 5's left arm. The incident report documented that Staff B evaluated Resident 5 with their spouse at the bedside and observed swelling and deep purple discoloration on the inside of the resident's left upper arm. The incident report further documented that the cause of the injury was unknown, and no falls had been reported.

Review of the progress note, dated 04/24/2026, documented that Resident 5 complained of arm pain. The note documented that 911 was activated, and Resident 5 was transported to the hospital for further evaluation.

Review of the progress note, dated 04/25/2026, documented the hospital staff informed the facility that the resident sustained a fracture.

Review of Resident 5's records contained no evidence that the facility investigated or determined when, where, or how Resident 5 sustained the bruising, swelling, skin tear and left arm fracture. The records contained no documented investigation actions, witness interviews, or conclusions regarding the circumstances or cause of the injuries or measures implemented to prevent similar occurrences.

On 07/15/2026 during an interview at 12:23 PM, Staff B shook their head in agreement to confirm that thorough investigation was not completed.

This is a repeat deficiency previously cited on 10/28/2024 for subsection (1).

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**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) 8/7/2026 Date

**WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:**

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(5) Appropriate behavioral interventions, if needed;

**This requirement was not met as evidenced by:**

Based on record review and interview, the facility failed to include wound and skin care interventions in the negotiated service agreement for 3 of 3 residents (Resident 3, Resident 6, and Resident 7). The facility failed to include behavioral interventions and an alternate plan for 1 of 3 residents (Resident 3) when home health could not complete the assessment or obtain treatment orders. This failure placed Resident 3, Resident 6, and Resident 7 at risk of delayed or unmet care and worsening skin conditions.

Findings included...

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RESIDENT 3
Review of resident 3's progress note dated 07/03/2026 documented that resident's feet were both in bad condition.

The progress note dated 07/13/2026 documented that Resident 3 had a rash present around their waist, inner thighs, bilateral buttocks, and groin. The note documented that Resident 3 resisted a home health assessment, would not allow the nurse to touch their feet or observe the rash, and attempted to hit a staff member. The note further documented that Resident 3's primary care provider was unresponsive, which limited home health's ability to obtain treatment orders.

Review of Resident 3's Negotiated Service Agreement (NSA), last modified on 05/30/2026, showed no documentation of any open areas to Resident 3's feet or the rash around their waist, inner thighs, bilateral buttocks and groin. The NSA documented that the resident had poor judgement, required supervision, and displayed occasional aggressive behavior. The NSA did not include any behavioral interventions for staff to follow when they provided care and Resident 3 became resistive to care or aggressive. The NSA did not identify any staff and home health responsibilities or include an alternate plan to obtain an assessment and treatments when home health was unable to provide the care.

RESIDENT 6
Review of the facility's records showed Resident 6 had a wound that was not identified in their most current NSA. The NSA did not include a plan to monitor the wound or address necessary interventions.

RESIDENT 7
Review of the facility's records showed Resident 7 had a wound that was not identified in their most current NSA. The NSA did not include a plan to monitor the wound or address necessary interventions.

On 07/15/2026 at 12:26 PM during an interview, Staff A, Executive Director, and Staff B, Resident Care Director, confirmed that Resident 3, Resident 6, and Resident 7s' negotiated service agreements were not updated to include wound care interventions.

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**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) 8/7/2026 Date

**WAC 388-78A-2420 Record retention.**

(3) The assisted living facility must maintain all documentation filed in a closed resident record, on the assisted living facility premises for six months after the date the resident leaves the assisted living facility and on the assisted living facility premises or another location for five years after the date the resident leaves the assisted living facility.

**This requirement was not met as evidenced by:**

Based on interview and record review, the facility failed to maintain a complete closed record on the facility premises for 1 of 1 resident (Resident 4). This failure delayed the department's investigation and placed all residents at risk of a decline in overall health from unidentified care needs that were not being met.

Findings included...

Review of the facility's "Internal Occurrence Report" dated, [redacted]/2026, showed Resident 4 passed away on [redacted]/2026. During the on-site investigation, the department staff requested Resident 4's closed record, including the negotiated service agreement.

During an interview on 07/14/2026 at 12:23 PM, Staff A, the Executive Director, stated that the facility had implemented a new electronic record system and Resident 4's records were unavailable. Staff A stated that the facility needed to contact its corporate office to obtain the requested records.

On 07/15/2026, Resident 4's records were provided to the department staff. Review of the records showed no negotiated service agreement. Record review showed that fewer than six months had passed since Resident 4's death, and the complete closed records were not maintained on the facility premises, as required.

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**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) Date 8/7/2026

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