STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

11/02/2023

MARYSVILLE SPECIAL CARE COMMUNITY LLC
THE COTTAGES AT MARYSVILLE
1216 GROVE STREET
MARYSVILLE, WA 98270

RE: THE COTTAGES AT MARYSVILLE License # 2149

Dear Administrator:

This letter addresses Compliance Determination(s) 31370 (Completion Date 10/19/2023) and 25122 (Completion Date 07/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/19/2023 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-2630-1-b, WAC 388-78A-2630-1-a

The Department staff who did the on-site verification:
Christine Banta, Community Complaint investigator

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: THE COTTAGES AT MARYSVILLE
License/Cert.#: 2149
Compliance Determination #: 25122
Investigator: Teresa Pederson-Tuley
Provider Type: Assisted Living Facility
Intake ID: 85400
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 06/09/2023 through 07/27/2023
Complainant Contact Date(s): 06/09/2023, 07/31/2023

Allegation(s):
Allegation that the Named Resident (NR) had injuries of unknown origin.

Investigation Methods:

Sample:	Total residents: 48 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Dining Resident to resident interactions Staff to resident interactions
Interviews:	Nursing staff Executive Director Family members
Record Reviews:	Medical records Hospital records Incident investigation Facility policies Personnel files

Investigation Summary:
According to observation, interview and record review:
The facility discovered the injuries, the family was notified and transported the NR to the hospital where a head injury and bruising on the neck were discovered. The facility investigated the incident and failed to make an immediate report to the hotline and law enforcement. A citation was issued for WAC 388-78A-2630 Reporting abuse and neglect.

Conclusion / Action:

- [x] 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 #: 2149	Compliance Determination # 25122
Plan of Correction	THE COTTAGES AT MARYSVILLE	Completion Date
Page 1 of 4	Licensee: MARYSVILLE SPECIAL CARE COMMUNITY LLC	07/27/2023

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 06/09/2023 and 07/13/2023 of:

THE COTTAGES AT MARYSVILLE
1216 GROVE STREET
MARYSVILLE, WA 98270

This document references the following complaint number(s): 85400, 85513

The following sample was selected for review during the unannounced on-site visit: 3 of 48 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Teresa Pederson-Tuley, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Kim Ripley
Residential Care Services

08/03/2022
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 8/3/23

XX

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to report a suspected physical abuse injury for 1 of 3 sampled residents (Resident 1) to law enforcement and the Department. The failure placed Resident 1 and all residents in the facility at risk for harm and a diminished quality of life.

Findings included...

Review of the facility policy titled "Abuse-Neglect-Exploitation" revised 09.28.20 showed

Reporting/Notifications: Staff Responsibilities

1. It is the responsibility of each staff member to immediately contact the department Hotline directly regarding suspected or alleged abuse, neglect, or exploitation.

2. Any staff member to witness, receive report, suspect, or become aware of the abuse, neglect, abandonment, exploitation, sexual, or physical assault of a resident is responsible for notifying Director of Nursing as well as reporting directly to the State Hotline as soon as possible once they have ensured that all residents are safe but no later than the end of the shift. If staff is unable to contact Director of Nursing, he/she will need to contact and report to facility Administrator.

3. Employee that first encounters, receives report, or becomes aware of allegation of abuse/neglect/exploitation is responsible for reporting incident to DSHS Hotline via online

report https://www.dshs.wa.gov/altsa or telephone call 1-800-562-6078.

Resident 1 was admitted to the facility on [redacted]/2022, with a diagnosis of [redacted] and [redacted] The resident was cognitively impaired and required full assistance from staff for physical transfers, activities of daily living and medication management

Review of the Investigation Report dated 06/12/2023 showed Resident 1 approached Staff E, Caregiver, and stated that someone had hit her in the head. Staff E looked at Resident 1's head, and noted a large area described as the size of a tennis ball, that was swollen, discolored and bleeding. Staff E stated that the injury was reported to Staff A, Director of Nursing. The witness statement dated 06/06/2023 from Staff E showed the injury was discovered.

Record Review of Progress Notes dated 06/06/2023, 06/07/2023 and 06/08/2023 showed that Resident 1's injuries were not documented, and that no notifications to the physician, family, the hotline or law enforcement had been made. A documented "Late Entry" on 06/08/2023 at 10:34 AM showed that Staff A documented bruising on the back of Resident 1's neck, and a soft area on the back of the head.

On 06/09/2023 at 10:55 AM Staff A was asked what the facility policy was for reporting an injury of unknown origin. Staff A stated that a report to the physician, family, hotline and law enforcement was to be made immediately. Staff A stated that she did not call the hotline or law enforcement.

On 06/09/2023 at 11:05 AM Staff B, Caregiver/Med Tech, stated the facility policy for reporting an injury of unknown origin, was to report to the hotline right away. Staff B stated that she did not call the hotline because she was told not to.

On 06/09/2023 at 11:20 AM Staff C, Caregiver/Med Tech, stated the facility policy for reporting an injury of unknown origin, was to report to the hotline right away. Staff C stated that she did not call the hotline because she was told not to.

On 06/09/2023 at 11:30 AM Staff D stated, Caregiver, the facility policy for reporting an injury of unknown origin, was to report to the hotline right away. Staff D stated that she did not call the hotline because she was told not to.

Review of Department records showed no report was made by the ALF until three days after the incident.

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Page 4 of 4	Licensee: MARYSVILLE SPECIAL CARE COMMUNITY LLC	07/27/2023

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 MARYSVILLE is or will be in compliance with this law and / or regulation on (Date) 8/22/2023

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

Julia Kinser
Administrator (or Representative)

8/3/2023
Date