STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

04/11/2025

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

RE: THE COTTAGES AT MARYSVILLE # 2149

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 57849 (Completion Date 04/11/2025) and 50282 (Completion Date 02/10/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/11/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

WAC 388-78A-2710 Disclosure of services.

(2) The assisted living facility must provide the services disclosed.

The Department staff who did the On Site verification:
Karen Glover, Complaint Investigator

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

Sincerely,

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 #: 50282
Investigator: Karen Glover
Provider Type: Assisted Living Facility
Intake ID: 147689
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 09/20/2024 through 02/10/2025
Complainant Contact Date(s): 09/20/2024

Allegation(s):

1-The Named Resident (NR) had a blood sugar over 800, a broken clavicle, a stage 2 pressure sore on their coccyx and a mark on their arm that resembled a hand print.
2-The NR was a diabetic and the facility was not checking their blood sugars or providing a diabetic diet.
3-The NR had a pile of dirty clothes in their bathroom. The facility was not helping the NR with dressing.
4- The NR was not receiving supervision..

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 6 Closed records sample size: 0
Observations:	Resident rooms Staff to resident interactions
Interviews:	Nursing staff Family members Administration
Record Reviews:	Medical records Hospital records Incident investigation Negotiated Service agreement

Investigation Summary:

1. The NR was a new admit to the facility. The NR had been living at home and was transferred to the facility because of frequent falls and dementia. On the second day, the NR had an unwitnessed fall, no injuries were noted at the time of the fall. The following day the NR developed some bruising on their left shoulder and left forearm. The NR started to complain of pain with movement of the left arm. The NR's family was called, and they provided transportation to the hospital for evaluation. Review of hospital records showed the NR had a fractured clavicle and multiple healed rib, vertebral and pelvic fractures and bruising from the fall. No

documentation noting a bruise resembling a hand print. Bruising represented different stages of healing. Review of the NR's progress notes from the facility showed no skin issues had been documented. Review of the wound care consult dated [redacted]/2024 (5 days after admitted to the hospital) showed a stage 1 ruptured blister on their left buttock. Lab work was drawn at the hospital which showed high glucose. Failed practice was found regarding non-concentrated sweets not being available. A citation was issued for non-compliance of WAC 388-78A-2710 (2) Disclosure of services.
2. Record review of the Disclosure of Services showed the facility does not provide diabetic management. Review of the NR's admission orders showed NR to be receiving a general, non concentrated sweets, pureed diet. No blood glucose checks were ordered. Review of hospital records showed the NR was well-nourished. A1C (blood test that measures your average blood sugar level over the past 3 months) drawn at hospital was high at 11.5. (the higher the number, the higher your blood glucose levels have been on average. High is over 9.0) Failed practice was found regarding non-concentrated sweets not being available. A citation was issued for non-compliance of WAC 388-78A-2710 (2) Disclosure of services.
3. The NR's pre-admission assessment showed the NR was a minimum assist with dressing and had just recently moved into the facility less than one week. Interview revealed the residents laundry is done on the first shower day of the week. Observations throughout the cottages showed no excessive piles of dirty laundry in other resident rooms. No failed practice was identified.
4. The NR's progress notes showed the NR was on alert charting (charting completed by facility staff each shift to monitor the resident) as a new admit to the facility. Review of the NR's Medication administration record showed the NR was receiving medications as ordered. Interview with staff showed the NR was participating in activities and eating meals with the other residents. No failed practice was identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: THE COTTAGES AT MARYSVILLE
License/Cert.#: 2149
Compliance Determination #: 50282
Investigator: Karen Glover
Provider Type: Assisted Living Facility
Intake ID: 147533
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 09/20/2024 through 02/10/2025
Complainant Contact Date(s): 11/15/2024

Allegation(s):

1-The Named Resident (NR) NR had fallen which resulted in a fractured collarbone and bruising.
2-The NR was shaken and disheveled.
3-The NR was diabetic, and the facility refused to accommodate the NR with a diabetic diet.

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 6 Closed records sample size: 0
Observations:	Residents Dining Resident rooms Staff to resident interactions
Interviews:	Family members Nursing staff Administration Medical provider
Record Reviews:	Hospital records Medical records Incident investigation Facility policies

Investigation Summary:

1. The Named Resident (NR) was a recent admit to the facility and had been living independently with a history of falls at home. On the second day, the NR was found on the floor in front of the refrigerator in the cottage. No injuries were noted at the time of the fall. The following day the NR developed some bruising on their left shoulder and left forearm. The NR started to complain of pain with movement of the left arm. The NR's family was called and they provided transportation to the hospital for evaluation. The facility initiated an investigation and notified the medical provider and the department's hotline. After the fall, the facility had placed the NR

on alert charting (charting done by facility staff per shift to monitor changes with the NR) and had requested a physical therapy evaluation. Review of hospital records showed the NR had a fractured clavicle and multiple healed rib, vertebral and pelvic fractures, with bruising representing different stages of healing. No failed practice was identified.
2. The facility stated that the NR was sent to the hospital following a fall. The NR was wearing a sweatshirt that had a stain, and the family declined to have facility staff change the NR into a clean sweatshirt before they left the facility. The NR was observed at the emergency room and the hospital records showed the NR was not "ill-appearing or toxic appearing." No failed practice was identified.
3. The disclosure of services show the facility did not provide diabetic management. The NR did not have medical provider orders for a diabetic diet or glucose monitoring. The NR did have an order for non-concentrated sweets. Failed practice was found regarding non-concentrated sweets not being available. A citation was issued for noncompliance with WAC 388-78A-2710 (2) Disclosure of services.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: THE COTTAGES AT MARYSVILLE
License/Cert.#: 2149
Compliance Determination #: 50282
Investigator: Karen Glover
Investigation Date(s): 09/20/2024 through 02/10/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 147475
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):

1. The Named Resident (NR) had a fall with a clavicle fracture.
2. The NR had a blood sugar over 800 and was admitted to the hospital for diabetic complications.
3. The NR "almost had a heart attack".

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 6 Closed records sample size: 0
Observations:	Residents Activities Resident rooms Staff to resident interactions
Interviews:	Nursing staff Residents Family members Administration
Record Reviews:	Facility policies Incident investigation Negotiated Service Agreement

Investigation Summary:

1.The Named Resident (NR) was a recent admit to the facility and had been living independently with a history of falls at home. The NR was found on the floor in front of the refrigerator in the cottage. No injuries were noted at the time of the fall. The following day the NR developed some bruising on their left shoulder and left forearm. The NR started to complain of pain with movement of the left arm. The NR's family was called and they provided transportation to the hospital for evaluation. The facility initiated an investigation and notified the medical provider and the department's hotline. After the fall, the facility had placed the NR on alert charting and had requested a physical therapy. Review of hospital records showed the NR had a fractured clavicle and bruising from the fall, Bruising represented

different stages of healing and multiple healed rib, vertebral and pelvic fractures. No failed practice was identified.
2. Review of hospital records showed the NR's blood sugar was 847 (normal range 60-100) and A1C (blood test that measures your average blood sugar level over the past 3 months) drawn at the hospital was high at 11.5. (the higher the number, the higher your blood glucose levels have been on average. High is over 9.0) Failed practice was found regarding non-concentrated sweets not being available. A citation was issued for non-compliance of WAC 388-78A-2710 (2) Disclosure of services.
3.Review of hospital records showed no indication of the NR having a heart attack. Troponin level (cardiac enzyme) was drawn, which was within normal limits. No failed practice was identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: THE COTTAGES AT MARYSVILLE
License/Cert.#: 2149
Compliance Determination #: 50282
Investigator: Karen Glover
Investigation Date(s): 09/20/2024 through 02/10/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 162124
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):
The Named Resident (NR) did not receive medications as prescribed.

Investigation Methods:

Sample:	Total residents: 42 Resident sample size: 6 Closed records sample size: 0
Observations:	Resident rooms Staff to resident interactions Medication administration
Interviews:	Family members Nursing staff Administrator
Record Reviews:	Medical records Incident investigation MAR

Investigation Summary:
NR was receiving assistance with medication management and administration. Staff discovered NR had not received medication as ordered by prescribing medical provider. Facility notified the medical provider and the NR's family. Facility initiated an incident report and placed resident on alert charting. Medical provider ordered weekly lab draw to monitor for any adverse effects. NR required a blood transfusion. Failed practice was identified. A citation was issued for non-compliance with WAC 388-78A-2210 (2)(b) Medication Services.

Conclusion / Action:

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

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 09/20/2024 and 01/16/2025 of:

THE COTTAGES AT MARYSVILLE
1216 GROVE STREET
MARYSVILLE, WA 98270

This document references the following complaint number(s): 147689, 147533, 147475, 162124

The following sample was selected for review during the unannounced on-site visit: 6 of 42 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Karen Glover, Complaint Investigator
Cynthia Chenot-Potter, 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.

Residential Care Services

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

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to give medications as prescribed to 1 of 3 residents (Resident 1) who required medication administration for 12 days. These failures resulted in Resident 1 receiving 12 additional doses of medication and placed the resident at risk for medical complications.

Findings included…

Undated face sheet showed Resident 1 was admitted to the ALF on [redacted]/2022 with multiple diagnoses including [redacted].

Review of Resident 1's service plan dated 08/13/2024 showed Resident 1 was to receive staff medication administration of all medications.

Review of Resident 1's Medication Administration Record (MAR) for the month of October 2024 showed to administer Revlimid 5mg (a chemotherapy medication prescribed to treat cancer) daily for 14 days, then off for 14 days. The cycle for October

started on 10/09/2024 and should have ended on 10/22/2024. The medication was given daily from 10/09/2024 through 11/12/2024 for a total of 26 days in a row, an additional 12 days/doses of the medication.

A record review of the facility incident report dated 11/13/2024, showed that the medication technician had noticed the medication bottle was empty and took it to Staff D, Resident Care Coordinator, who discovered the medication had not been taken according to the prescriber's orders.

On 12/19/2024 at 12:28 PM Collateral Contact 1 (CC 1) stated that Resident 1 was to receive their chemotherapy medication on a 2-week cycle that included the Resident 1 to take it daily for 14 days on then to be off of the medication for 14 days and then to repeat the pattern. On 11/13/2024 CC 1 was notified by the ALF that Resident 1 had received the medication daily for 26 days in a row before it was discovered that there had been an error in the scheduled pattern. CC 1 stated that on 11/14/2024 Resident 1's oncologist ordered weekly blood work to monitor for any adverse effects. CC 1 stated that on 11/27/2024 Resident 1's hemoglobin (hgb) (blood cells that pick up oxygen from the air that is breathed and delivers it everywhere in the body) level was 8.5 (normal range is 12 to 17) and on 12/11/2024 the hgb level was 8.0. CC 1 stated that Resident 1 was dizzy, confused, tired, and required a blood transfusion.

On 01/10/2025 at 09:44 AM Staff A, Executive Director, stated that the NR receiving too much medication was an error caused by staff who didn't notice until the medication had run out on 11/13/2024.

On 01/16/2025 at 11:30 AM Staff B, Director of Nursing Services, stated when reviewing Resident 1's MAR for October 2024 staff had missed that this medication had no dates crossed out to indicate not to give the medication on those days.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2710 Disclosure of services.

(2) The assisted living facility must provide the services disclosed.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to provide non-concentrated sweets as identified in the ALF's disclosure of services for 2 of 2 residents (Resident 2 and 3) who were ordered to receive a diet of reduced sugar. This failure resulted in the residents receiving food with sugar, and placed Resident 2 and 3 at risk for diabetic complications.

Findings included…

Review of the ALF's Disclosure of Services, undated, showed sugar free desserts and snacks were available.

Resident 2
Undated face sheet showed Resident 2 was admitted to the facility on [redacted]/2024 with a diagnosis of [redacted] and [redacted].

Record review of Resident 2's pre-admission assessment, dated 08/27/2024 and completed by Staff B, Director of Nursing, showed no diet type had been identified only that Resident 1 had a good appetite and was independent with feeding.

Record review of Resident 2's admission physician orders dated 09/06/2024 showed that Resident 2 was to have a general, pureed diet with non-concentrated sweets (a diet that has no added sugar but uses a sugar substitute).

Resident 3
Undated face sheet showed Resident 3 was admitted to the facility on [redacted]/2021 with a diagnosis of [redacted].

Record review of Resident 3's order summary dated 01/14/2025 showed that Resident 3 was to have a non-concentrated sweets diet.

Record review of Resident 3's service plan dated 11/25/2024 showed that Resident 3 was on a non-concentrated sweets (NCS) diet and staff were to encourage non-sugar choices.

On 01/14/2025 at 08:41 AM, Staff C, Dietary Manager stated that they had no sugar free snacks or desserts in the facility for the residents on non-concentrated sweet diet.

On 01/16/2025 at 11:20 AM, Staff A, Executive Director stated that they changed food vendors 2 years ago and they had not realized they had not been receiving sugar free desserts or snacks from the new vendor. Staff A stated that they had been receiving sugar free syrup and jam from the new vendor.

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)_____ .

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

_____ _____

Administrator (or Representative) Date