STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Snohomish ALC LLC
Cottages of Snohomish
1124 Pine Ave
Snohomish, WA 98290

RE: Cottages of Snohomish # 2740

Dear Administrator:

This document references Compliance Determination 55822 (04/23/2025), which included complaint number(s) 168155, 169638, 168859, 169834, 169433.

The Department completed a complaint investigation of your Assisted Living Facility on 04/23/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Wesler Dumecquias, Community Complaint Investigator

Consultation:

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:

(i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and

The Assisted Living Facility (ALF) failed to ensure that pendants were responded to within a reasonable time. The ALF care staff pagers were supposed to be in the possession of the care staff at all times while they are at work. The Pagers were not in the possession of the care staff at this time and were found in the Medication cart drawers. The ALF reminded the care staff and included in their in -service a review of their protocol in responding to pendants. A consultation was done under WAC 388-78A-2930- Communication System.

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(9) Documentation consistent with WAC 388-78A-2120 Monitoring resident well-being.

The ALF staff followed the care plan. Staff were doing showers but were not consistently documenting them in their ADL task. The ALF reminded and had an in-service with the care staff regarding the importance of recording their observations, residents refusals and ensuring continuity of care. The ALF fixed their documentation and ensured the care and services provided according to the care plan were documented.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:

- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:

- Inspect the facility to determine if you have corrected all deficiencies.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  - What specific deficiency or deficiencies you disagree with;
  - Why you disagree with each deficiency; and
  - Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - Send your request to:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

If You Have Any Questions:

- Please contact me at (253)281-1245.

Sincerely,

Anthony Devito, Field Services Administrator
Region 2, Unit Z
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Cottages of Snohomish
Provider Type: Assisted Living Facility

License/Cert.#: 2740
Intake ID: 168859
Compliance Determination #: 55822
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 03/05/2025 through 04/23/2025
Complainant Contact Date(s): 03/05/2025

Allegation(s):

1. The Assisted Living Facility (ALF) were not responding to residents call buttons.
2. The Named Resident (NR) left the ALF unsupervised and there were no staff visible.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 8 Closed records sample size: 1
Observations:	Resident rooms Resident care equipment Residents Activities Dining Pull cords/pendants
Interviews:	Nursing staff Residents Family members Administrator
Record Reviews:	Staff patterns Facility policies Care plans progress notes

Investigation Summary:

1. Observation and interview showed a failed practice when the call pendant buttons from sampled residents were tested and no staff responded for almost an hour. The Emergency call buttons and the call pendant were connected to the care staff 's pagers. The ALF staff were supposed to have the pagers in their possessions but they did not have them at the time the pendant calls were made. The ALF staff found the pagers and ensured that all staff would have them in their possessions while working. A consultation was issued under WAC 388-78A-2930 (b) (i) Communication system.

2. The Assisted Living Facility (ALF) increased the staffing in the Memory care unit (MCU) with two care staff for their Morning and Evening shifts. One of the two ALF staff was a Med Tech and both were dedicated for the MCU only. During night shift, a caregiver and a Med Tech would be assigned. The night shift Med Tech, at the time, floats to pass medications to the Assisted Living Residents if needed. The ALF staff implemented a system of adding an extra staff they call it as "universal/float staff" which would help with showers, housekeeping and maintenance tasks. During the unannounced visits, there were two staff providing care and supervision for the memory care unit. 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: Cottages of Snohomish
Provider Type: Assisted Living Facility

License/Cert.#: 2740
Intake ID: 169834
Compliance Determination #: 55822
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 03/05/2025 through 04/23/2025
Complainant Contact Date(s): 03/05/2025

Allegation(s):

1. The Named resident (NR) was not being supervised by the Assisted Living Facility (ALF) staff. The ALF staff were allowing the NR walk on their own despite being a high fall risk.
2. The ALF was filthy.
3. The ALF staff were not showering the NR. The NR was found by family sitting on their stool.
4. There were no staff visible in the ALF.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 8 Closed records sample size: 1
Observations:	Residents Activities Dining Resident care equipment Resident rooms Bathroom Laundry room
Interviews:	Nursing staff Residents Family members Administrator
Record Reviews:	Facility policies Staff patterns care plans progress notes Shower logs

Investigation Summary:

1. Observation showed the Named Resident (NR) was quietly seated on their own at the common area. Interview showed staff would cue and on standby when the NR

would be ambulating. The staff continued monitoring the NR's mobility and acclimation into the ALF. No failed practice was identified.
2. Observation and interview showed the Cottages common areas and Residents room were organized, floor was free of clutters, dust and looked swept and mapped. The Laundry room was free of any odors and smelled with a newly laundered clothing. The Common bathroom were free from any odors from urine or bowel movements. The ALF staff implemented a system of adding an extra staff they call it as "universal/float staff" which would help with showers, housekeeping and maintenance tasks. Interview with families indicated there was an improvement in the care and verbalized not having concerns at this time. No failed practice was identified.
3. The ALF staff followed the care plan. Staff were doing showers but were not consistently documenting them in their ADL task. The ALF reminded and had an in-service with the care staff regarding the importance of recording their observations, residents refusals and ensuring continuity of care. The ALF fixed their documentation and ensured the care and services provided according to the care plan were documented. A consultation was done under WAC 388-78A 2410 (9). Content of records.
4. The Assisted Living Facility (ALF) increased the staffing in the Memory care unit (MCU) with two care staff for their Morning and Evening shifts. One of the two ALF staff was a Med Tech and both were dedicated for the MCU only. During night shift, a caregiver and a Med Tech would be assigned. The night shift Med Tech, at the time, floats to pass medications to the Assisted Living Residents if needed. The ALF staff implemented a system of adding an extra staff they call it as "universal/float staff" which would help with showers, housekeeping and maintenance tasks. During the unannounced visits, there were two staff providing care and supervision for the memory care unit. 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