STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

MALLON PLACE INC

MALLON PLACE INC
1724 W Mallon Ave
Spokane, WA 99201

RE: MALLON PLACE INC License # 1017

Dear Administrator:

This letter addresses Compliance Determination(s) 68479 (Completion Date 11/07/2025) and 65867 (Completion Date 09/19/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/07/2025 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-2320-1, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2240, WAC 388-78A-2660-1, RCW 70.129.140.1

The Department staff who did the on-site verification:
Jennifer Lee, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Community Field Manager
Region 1, Unit B
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 the unannounced on-site full inspection on 09/17/2025, 09/18/2025 and 09/19/2025 of:

MALLON PLACE INC
1724 W Mallon Ave
Spokane, WA 99201

The following sample was selected for review during the unannounced on-site visit: 7 of 48 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Jennifer Lee, Assisted Living Facility Licensor
Joy Pipgras, LTC Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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 — 09/24/2025 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) — 10/01/2025 Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff were nurse delegated before administering delegated injections for 2 of 6 staff (Staff C and G). This failure resulted in residents receiving delegated injections from staff that had not met qualifications to provide delegated injections.

Findings included...

Per WAC 246-840-930 (5) (10)(a)(b): criteria for nurse delegation, before delegating a nursing task, the registered nurse delegator:

-(5) Assesses the ability of the Nursing Assistant (NA) or Home Care Aid (HCA) to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.

-(8) (a) Verify that the nursing assistant or home care aide: Is currently registered or certified as a nursing assistant or home care aide.

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

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-(8) (a) Verify that the nursing assistant or home care aide: Is currently registered or certified as a nursing assistant or home care aide.

-(10) If the registered nurse delegator determines delegation is appropriate, the nurse:

(10)(a) Discusses the delegation process with the patient or authorized representative, including the level of training of the nursing assistant or home care aide delivering care.

-(10)(b) Obtains written consent. Verbal consent may be acceptable if written consent is obtained within 30 days.

Review of the facility's Disclosure of Services showed that the facility would provide diabetic management if the resident was able to administer their own injections.

Review of Resident 3's Face Sheet showed a diagnosis of [redacted].

Review of Resident 3's Augmented Standard Assessment (the facility's combined assessment and negotiated services agreement), dated 06/25/2025, showed a diagnosis of [redacted]. Further review showed that it stated that if Resident 3 was unable to hold the Dexcom Sensor (a sensor that continually measures their blood sugar) in place, staff could assist with positioning the sensor and the resident could push the sensor into their skin independently.

Review of Resident 3's July 2025 Medication Administration Records (MARs) showed Staff G, Uncredentialed Caregiver, had administered (injected the sensor into the skin) Resident 3's Dexcom Blood Sugar Sensor on 07/03/2025.

Review of Resident 3's August 2025 MARs, showed Staff C, Housekeeping Supervisor/Uncredentialed Caregiver, had administered Resident 3's Dexcom Blood Sugar Sensor on 08/08/2025 and 08/17/2025.

Review of the facility's staff list showed that Staff G's was hired on 06/23/2025 as a caregiver and had a pending HCA license (not currently active).

Review of Staff C's undated personnel file showed they were hired on 04/28/2025 as a caregiver and had a pending HCA license (not currently active).

In an interview on 09/18/2025 at 9:50 AM Resident 3 stated that facility caregivers had been inserting their Dexcom Sensors every 10 days.

In an interview on 09/18/2025 at 01:15 PM, Staff H, Nursing Assistant Registered, stated that they had seen Staff C and Staff G inject the Dexcom Sensor into Resident 3's arm.

In an interview on 09/19/2025 at 11:15 PM, Staff F, Alternative Administrator, stated that it was a "huge oversight" that Resident 3 was not injecting themself with their Dexcom and "did not know it was an issue."

Review of facility documents showed there were no resident nurse delegation assessments or resident consent forms.

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, MALLON PLACE INC is or will be in compliance with this law and / or regulation on (Date) 10/1/2025.

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

Administrator (or Representative) [signature] Date 10/1/2025

* All staff re-trained on delegation procedure

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 observation, interview and record review, the facility failed to ensure that medications were available to be administered as ordered for 1 of 7 residents (Resident 2). This failure resulted in the resident not receiving their medication for seven days and placed the resident at risk of increased behaviors.

Findings included...

Review of Resident 2's Face Sheet showed a move in date of [redacted]/2018 and that the resident had a diagnosis of [redacted].

Review of Resident 2's Augmented Standard Assessment (the facility's combined assessment and negotiated services agreement), dated 01/20/2025, showed Resident 2 required assistance with medication administration.

In an interview on 09/19/2025 at 11:15 PM, Staff F, Alternative Administrator, stated that it was a "huge oversight" that Resident 3 was not injecting themself with their Dexcom and "did not know it was an issue."

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Findings included…

Review of Resident 2's Face Sheet showed a move in date of [redacted]/2018 and that the resident had a diagnosis of [redacted].

Review of Resident 2's Augmented Standard Assessment (the facility's combined assessment and negotiated services agreement), dated 01/20/2025, showed Resident 2 required assistance with medication administration.

Review of Resident 2's September 2025 Medication Administration Record showed the resident had an order for risperidone (a medication use to treat mental health disorders) to be given once daily. Further review showed Resident 2 did not receive the risperidone from 09/05/2025 to 09/11/2025, with documentation stating that the medication was not available.

Observation on 09/18/2025 at 11:10 AM showed Resident 2 in the smoking area wearing dirty clothing. In an interview at that time, Resident 2 stated there was a conspiracy at the facility, that the food was poisoned and was making inappropriate sexual comments.

In an interview on 09/19/2025 at 9:49 AM, Staff F, Alternate Administrator, confirmed that Resident 2 did not receive their risperidone for seven days due to an error in their system.

*med exceptions printed/reviewed daily & sent to Alt. Admin for review.

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Administrator (or Representative) — Date: 10/01/2025

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide care in a manner which promoted dignity and resident right for 1 of 7 residents (Resident 3) who required toileting assistance. This failed practice caused distress for Resident 3 and left the resident at risk for skin breakdown as they were unable to easily contact staff for assistance.

Review of Resident 2's September 2025 Medication Administration Record showed the resident had an order for risperidone (a medication use to treat mental health disorders) to be given once daily. Further review showed Resident 2 did not receive the risperidone from 09/05/2025 to 09/11/2025, with documentation stating that the medication was not available.

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Findings included…

Observation on 09/18/2025 at 9:50 AM showed Resident 3's bed was on the opposite side of the room from the only pull cord call light in their room.

Review of the facility's Disclosure of Services showed the facility would provide toileting needs and incontinence (lack of voluntary control over urine or bowel movements-BMs) care.

Review of Resident 3's Face Sheet showed a diagnosis of [redacted].

Review of the facility's Characteristics Roster showed a diagnosis of [redacted] for Resident 3. Further review showed a need for maximum assistance with activities of daily living (the basic tasks that individuals perform to independently care for themselves, such as bathing, dressing, eating, using the toilet, and mobility) and a wound located in the peri-area (pubic area).

Review of Resident 3's Augmented Standard Assessment (the facility's combined assessment and negotiated services agreement), dated 06/25/2025, showed a diagnosis of [redacted]. The assessment showed that Resident 3 was unable to get to the toilet unassisted and may not be aware of the need to urinate or have a BM. Further review showed that Resident 3 had experienced frequent diarrhea which they could not manage on their own and required increased assistance with their incontinence briefs.

Review of Resident 3's Charting Notes, dated 06/20/2025 at 1:00 PM, showed that Resident 3 requested assistance with cleaning themselves and their wheelchair from an incontinent BM episode.

Review of Resident 3's Charting Notes, dated 06/29/2025 at 9:50 AM, showed that Resident 3 requested assistance with cleaning themselves and their wheelchair from an incontinent BM episode.

Review of Resident 3's Charting Notes, dated 07/06/2025 at 10:45 AM, showed that Resident 3 requested assistance with cleaning themselves and their wheelchair from an incontinent BM episode.

Review of Resident 3's Incident and Accident Investigation Reports, dated from 05/19/2025 to 6/29/2025, showed that Resident 3 requested assistance with cleaning themselves and their wheelchair from an incontinent BM episode on the following dates:

- 05/24/2025 at 8:30 AM
- 06/01/2025 at 10:39 AM
- 06/04/2025 at 1:00 PM
- 06/05/2025 at 8:20 AM
- 06/06/2025 at 9:00 AM
- 06/15/2025 at 7:30 AM
- 06/20/2025 at 1:00 PM
- 06/29/2025 at 9:50 AM

In an interview on 09/18/2025, at 9:50 AM, Resident 3 stated that they could not contact the staff easily because the call light was across their room by the exit door. Resident 3 further stated they were often incontinent of urine and BMs and that they could not summon staff for assistance without getting into their wheelchair and going over to the door. Resident 3 stated that this made them uncomfortable because they sat in their wheelchair in feces, that sometimes leaked out of their brief. Observation at that time showed Resident 3's bed was on the opposite side of the room from the only pull cord call light in their room.

In an interview on 09/18/2025 at 2:30 PM, Staff F, Alternate Administrator, stated that no residents had pendants to call staff and only had the pull cord call lights in the rooms.

1 Pull Cord moved next to her bed 9/19/2025.

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Administrator (or Representative)

10/01/2025
Date

- 05/24/2025 at 8:30 AM
- 06/01/2025 at 10:39 AM
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