STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

05/26/2026

MALLON PLACE INC
MALLON PLACE INC
1724 W Mallon Ave
Spokane, WA 99201

RE: MALLON PLACE INC # 1017

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 77952 (Completion Date 05/26/2026) and 74934 (Completion Date 04/01/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/26/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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.

The Department staff who did the On Site verification:
Amy Wright, NCI Complain Investigator

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

Residential Care Services
Investigation Summary Report

Provider/Facility: MALLON PLACE INC
Provider Type: Assisted Living Facility
License/Cert.#: 1017
Compliance Determination #: 74934
Intake ID: 217111
Investigator: Amy Wright
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 03/26/2026 through 04/01/2026
Complainant Contact Date(s): 03/23/2026, 04/01/2026

Allegation(s):
Resident ran out of pain medication early.

Investigation Methods:

Sample:
Total residents: 52
Resident sample size: 3
Closed records sample size: 0

Observations:
Alleged Victim
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Reporter
Assistant Administrator
Resident Care Coordinator
Alleged Victim

Record Reviews:
*Disclosure of Services
*Characteristic roster
*Staff roster
*Resident face sheets
*Resident care plans
*Provider orders
*Medication administration records
*Narcotic book entries
*Control and Accountability of Narcotics Policy
*Progress notes
*Hospital after-visit summary
*Pharmacy communication form
*Incident report

Investigation Summary:
Interview with facility management showed that facility staff lost track of the

Alleged Victim's narcotic pain medication for twelve days. Record review showed that the Alleged Victim went without their ordered pain medication for a period of time while awaiting pharmacy refill. Failed facility practice identified and cited under WAC 388-78A-2240 Nonavailability of medications.

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 #: 1017	Compliance Determination # 74934
Plan of Correction	MALLON PLACE INC	Completion Date
Page 1 of 3	Licensee: MALLON PLACE INC	04/01/2026

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 03/26/2026 of:

MALLON PLACE INC
1724 W Mallon Ave
Spokane, WA 99201

This document references the following complaint number(s): 217111

The following sample was selected for review during the unannounced on-site visit: 3 of 52 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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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 — 04/06/2026 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.

Administrator (or Representative) — 4/7/2026 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 facility failed to obtain prescribed medication in a correct and timely manner for 1 of 3 residents (Resident 1). This failed practice resulted in unmanaged pain for Resident 1.

Findings included...

Review of a Negotiated Service Agreement (NSA) for Resident 1, dated 03/26/2026, showed that facility staff were responsible for ordering the resident's medications. Review of the NSA showed that Resident 1 had severe pain issues associated with fibromyalgia (a chronic, long-term condition characterized by widespread musculoskeletal pain, fatigue, sleep disturbance and cognitive issues) and rheumatoid arthritis (an autoimmune disease where the immune system attacks the joint linings causing painful inflammation and stiffness). The NSA showed that Resident 1 admitted to the facility on [redacted]/2026.

In an interview on 03/26/2026 at 10:01 AM, Staff A, Assistant Administrator, stated that when Resident 1 admitted to the facility from an adult family home, Resident 1 came with hydrocodone (a narcotic medication used to treat pain) but there had been no active order for it. Staff A stated that Resident 1's hydrocodone ended up tucked away in a cupboard in an office. During the same interview, Staff B, Resident Care Coordinator, stated that on 03/13/2026, Resident 1's psychiatric care provider wrote a new order for Resident 1's scheduled hydrocodone. Staff B stated that on 03/15/2026,

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while the facility was waiting on delivery of the hydrocodone ordered by the psychiatric care provider, Resident 1 went to the emergency department where they got an order for hydrocodone as needed. During the same interview, Staff A stated that the pharmacy would not fill the orders for Resident 1's hydrocodone because the insurance company already paid for the medication the last time the order was filled by the adult family home. Staff A stated that the facility paid for Resident 1's hydrocodone so they would not have to go without it, but it did not arrive until 03/16/2026. During the same interview, Staff B stated that the hydrocodone that was sent by the adult family home was not found until 03/24/2026. Staff B stated they had not realized what was in Resident 1's intake medications. Staff B stated they could improve their intake process.

In an interview on 03/26/2026 at 10:27 AM, Resident 1 stated it had been "hell" since they returned to the facility a little over a week ago. Resident 1 stated they were on several medications for their chronic pain. Resident 1 stated that they went to the emergency room to get a hydrocodone order but said it took forever to get the medication.

Review of a Medication Administration Record (MAR) for Resident 1, dated March 2026, showed that the resident had not received their first dose of as-needed hydrocodone until 03/17/2026, two days after the as needed hydrocodone was ordered. The MAR showed that Resident 1 rated their pain at a "10" by the time the as needed hydrocodone was administered. Further review of the MAR showed that Resident 1 had not received their first scheduled dose of hydrocodone until 03/18/2026, five days after the scheduled hydrocodone was ordered.

This is a recurring citation previously cited on 09/19/2025.

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) 5/16/2026.

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

Administrator (or Representative) — Date 4/7/2026