STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

One Mallards Landing, LLC
The Lodge at Mallard's Landing
7083 Wagner Way NW
Gig Harbor, WA 98335

RE: The Lodge at Mallard's Landing License # 2064

Dear Administrator:

This letter addresses Compliance Determination(s) 32291 (Completion Date 11/15/2023) and 28447 (Completion Date 09/18/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/15/2023 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-2210-2

The Department staff who did the on-site verification:
Michael Goulet, Complaint Investigator

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: The Lodge at Mallard's Landing
License/Cert.#: 2064
Compliance Determination #: 28447
Investigator: Michael Goulet
Investigation Date(s): 08/22/2023 through 09/18/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 92578
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

1) Resident not administered polyethylene glycol (laxative, aka PEG or Miralax) by facility staff, "Resident given Miralax instead" (PEG and Miralax are the same medication)
2) PEG in overflow medication cart and staff did not alert nurse or re-order medication, only listed medication as 'not available'
3) Resident sent to hospital due to abdominal blockage, likely related to non-administration of PEG

Investigation Methods:

Sample:	Total residents: Resident sample size: 5 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms
Interviews:	Residents Staff
Record Reviews:	Medication administration records (MAR)

Investigation Summary:

1,2,3) Per interview with named resident, the medication (PEG) was available, but the resident did not take the medication due to their own refusal, stating they experienced excessive diarrhea due to this medication. Per record review of the named resident's medication administration record (MAR), the medication was not available and was not able to be found by facility staff from 7/18/23 through 8/1/23. There was no indication per facility MAR that staff took any action during this time other than noting that the medication was not available. Per staff interviews, it was more likely than not that the lack of this laxative medication did lead to the resident having a bowel blockage requiring hospitalization on [redacted]/23.
Cited as per WAC 388-78A-2210 (2) Medication 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 Lodge at Mallard's Landing
License/Cert.#: 2064
Compliance Determination #: 28447
Investigator: Michael Goulet
Investigation Date(s): 08/22/2023 through 09/18/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 92699
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

1) Resident not administered vaginal insert medication (Estradiol) by staff, leading to urinary tract infection

Investigation Methods:

Sample:	Total residents: Resident sample size: 5 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms
Interviews:	Residents Staff
Record Reviews:	Medication administration records (MAR)

Investigation Summary:

1) Per facility staff interview and record review of the named resident's medication administration records (MAR), the resident was not administered Estradiol vaginal insert on four occasions (7/3/23, 7/28/23, 7/31/23 and 8/11/23). One instance was stated (on the resident's MAR) as being related to the medication only being administered by nursing staff, which per remaining records was not factual. Two instances were related to the resident being otherwise predisposed at the scheduled time of administration, but no follow up attempt by staff was noted to have been made. The final instance was related to the medication not being available due to not having been refilled by facility staff. Per facility staff interview, the medication was intended to prevent urinary tract infection (UTI), and staff stated they felt the resident's diagnosis with a [redacted] was directly related to the missed administration of this medication.
Cited per WAC 388-78A-2210 (2) Medication 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 Lodge at Mallard's Landing
License/Cert.#: 2064
Compliance Determination #: 28447
Investigator: Michael Goulet
Investigation Date(s): 08/22/2023 through 09/18/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 93168
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

1) Resident pain medication (Oxycodone liquid) found to have been diverted as evidenced by adulteration of medication (medication removed from bottle and replaced with water).

Investigation Methods:

Sample:	Total residents: Resident sample size: 5 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms
Interviews:	Residents Staff
Record Reviews:	Medication administration record (MAR)

Investigation Summary:

1) Per facility staff interview, the resident's bottle of liquid Oxycodone (pain reliever) was noted to have been adulterated, as evidenced by a change in the color of the medication and staining to the label indicative of the medication being replaced with water. Per staff and resident interviews, the named resident had not used this medication and no harm was noted. Per staff, the facility has taken steps to secure narcotic medications, and to only receive narcotic medications in the future in tamper resistant and tamper evident packaging.
Consultation only per WAC 388-78A-2260 (1) Storing, Securing and Accounting for Medications (evidence available did not rise to level of citation)

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 Lodge at Mallard's Landing
License/Cert.#: 2064
Compliance Determination #: 28447
Investigator: Michael Goulet
Investigation Date(s): 08/22/2023 through 09/18/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 93466
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

1) "Hydralazine (blood pressure medication) held numerous times by staff due to wrong education"

Investigation Methods:

Sample:	Total residents: Resident sample size: 5 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms
Interviews:	Residents Staff
Record Reviews:	Medication Administration Records (MAR)

Investigation Summary:

1) Per record review of the named resident's medication administration records (MAR), there were numerous times when the medication in question (Hydralazine, blood pressure medication) was held by staff in accordance with the physician's orders (hold medication if systolic blood pressure less than 110 or diastolic blood pressure less than 60), but there were also multiple times (8) noted where this medication was held with no blood pressure reading noted. In four cases the medication was noted by staff to be "too close to previous administration" but in these instances administration would have been within appropriate parameters (within 30 minutes of time ordered) for administration. In one case the medication was stated by staff as being "too close to previous administration", but this was noted by staff more than one hour (11:52am) prior to the ordered time of administration (1:00pm), and no re-attempt to administer the medication within the order parameters was noted. In two cases no exception or administration was noted, and in one case the medication was appropriately held due to low diastolic blood pressure, but the blood pressure was not noted on the MAR.
Cited per WAC 388-78A-2210 (2) 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
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2064	Compliance Determination # 28447
Plan of Correction	The Lodge at Mallard's Landing	Completion Date
Page 1 of 3	Licensee: One Mallards Landing, LLC	09/18/2023

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 08/22/2023 and 09/14/2023 of:

The Lodge at Mallard's Landing
7083 Wagner Way NW
Gig Harbor, WA 98335

This document references the following complaint number(s): 92578, 92698, 93168, 93466, 96925

The following sample was selected for review during the unannounced on-site visit: 5 of 0 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Michael Goulet, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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 — 09/20/2023 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.

Statement of Deficiencies	License #: 2064	Compliance Determination # 28447
Plan of Correction	The Lodge at Mallard's Landing	Completion Date
Page 2 of 3	Licensee: One Mallards Landing, LLC	09/18/2023

Administrator (or Representative)

September 25, 2023
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 :

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure that 3 of 6 residents (Residents 1, 2 and 4) received their medication as ordered. This failure placed these residents at risk of potential harm.

Findings Included...

During an interview on 08/23/2023 at 11:40am, Facility Administrator (Staff A) stated that Resident 1 (R1) did not receive polyethylene glycol (Miralax, laxative medication) as ordered, and that this led to a bowel blockage requiring hospitalization for the resident on [redacted]/2023.

During an interview on 08/23/2023 at 11:40am, Staff A stated that Resident 2 (R2) did acquire a urinary tract infection (UTI, bladder infection), and that facility staff believed this was a direct result of UTI preventative medication (Estradiol vaginal insert) not being administered by facility staff.

During an interview on 08/23/2023 at 11:40am, Staff A stated that Resident 4's (R4) blood pressure medication was held by facility staff when the medication should have been administered to the resident.

Record review on 08/24/2023 at 7:00am of R1's Medication Administration Records (MAR) for July and August 2023 showed that R1 did not receive polyethylene glycol/ Miralax on 07/05/2023, 07/06/2023, 07/10/2023 and 07/18/2023 through 08/01/2023 due to this medication being unavailable per staff notation. There was no notation in the MAR of any action taken by staff in order to secure this medication for the resident or that administrative staff had been informed of this non-availability.

Record review on 08/24/2023 at 7:00am of R2's Medication Administration Records (MAR) for July and August 2023 showed that R2 missed a total of four doses of their Estradiol vaginal insert medication over this time. One dose on 07/03/2023 was not given due to staff noting incorrectly that only nursing staff could administer this medication, but there was no indication that any nursing staff were contacted regarding this missed dose or that

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 :

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure that 3 of 5 residents (Residents 1, 2 and 4) received their medication as ordered. This failure placed these residents at risk of potential harm.

Findings Included...

During an interview on 08/23/2023 at 11:40am, Facility Administrator (Staff A) stated that Resident 1 (R1) did not receive polyethylene glycol (Miralax, laxative medication) as ordered, and that this led to a bowel blockage requiring hospitalization for the resident on [redacted]/2023.

During an interview on 08/23/2023 at 11:40am, Staff A stated that Resident 2 (R2) did acquire a urinary tract infection (UTI, bladder infection), and that facility staff believed this was a direct result of UTI preventative medication (Estradiol vaginal insert) not being administered by facility staff.

During an interview on 08/23/2023 at 11:40am, Staff A stated that Resident 4's (R4) blood pressure medication was held by facility staff when the medication should have been administered to the resident.

Record review on 08/24/2023 at 7:00am of R1's Medication Administration Records (MAR) for July and August 2023 showed that R1 did not receive polyethylene glycol/ Miralax on 07/05/2023, 07/06/2023, 07/10/2023 and 07/18/2023 through 08/01/2023 due to this medication being unavailable per staff notation. There was no notation in the MAR of any action taken by staff in order to secure this medication for the resident or that administrative staff had been informed of this non-availability.

Record review on 08/24/2023 at 7:00am of R2's Medication Administration Records (MAR) for July and August 2023 showed that R2 missed a total of four doses of their Estradiol vaginal insert medication over this time. One dose on 07/03/2023 was not given due to staff noting incorrectly that only nursing staff could administer this medication, but there was no indication that any nursing staff were contacted regarding this missed dose or that

any other staff member subsequently administered this dose. One dose on 07/28/2023 and one dose on 07/31/2023 were missed due to the resident being unavailable at the scheduled time of administration (once due to a visitor and once due to a dentist visit), but there was no indication that staff attempted to administer the medication when the resident was available. One dose on 08/11/2023 was missed due to the non-availability of the medication.

Record review on 08/24/2023 at 7:00am of R4's Medication Administration Records (MAR) for July and August 2023 showed that R4 missed a total of seven doses of Hydralazine (blood pressure medication) during August 2023. On 08/01/2023 and on 08/20/2023, no medication was administered as scheduled at 1:00pm, with no exception (reason for non-administration) noted, and no resident blood pressure noted (as required per order parameters) to have been taken by facility staff. On 08/06/2023, 08/10/2023, 08/19/2023 and 08/22/2023 (all for 1:00pm dose) R4's Hydralazine was noted by staff to be held due to administration being "too close" to a previous or subsequent dose of the medication, although according to the times these exceptions were noted the administration of the medication would have been within order parameters. One dose on 08/02/2023 was also noted as being missed due to being "too close to the previous dose," but this exception was noted over an hour before (11:52am) the medication was scheduled for being administered (1:00pm). There was no indication that staff attempted to administer the medication within the time parameters of the order as written.

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 Lodge at Mallard's Landing is or will be in compliance with this law and / or regulation on (Date) 10-25-2023

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

Administrator (or Representative) 9-25-2023 Date

any other staff member subsequently administered this dose. One dose on 07/28/2023 and one dose on 07/31/2023 were missed due to the resident being unavailable at the scheduled time of administration (once due to a visitor and once due to a dentist visit), but there was no indication that staff attempted to administer the medication when the resident was available. One dose on 08/11/2023 was missed due to the non-availability of the medication.

Record review on 08/24/2023 at 7:00am of R4's Medication Administration Records (MAR) for July and August 2023 showed that R4 missed a total of seven doses of Hydralazine (blood pressure medication) during August 2023. On 08/01/2023 and on 08/20/2023, no medication was administered as scheduled at 1:00pm, with no exception (reason for non-administration) noted, and no resident blood pressure noted (as required per order parameters) to have been taken by facility staff. On 08/06/2023, 08/10/2023, 08/19/2023 and 08/22/2023 (all for 1:00pm dose) R4's Hydralazine was noted by staff to be held due to administration being "too close" to a previous or subsequent dose of the medication, although according to the times these exceptions were noted the administration of the medication would have been within order parameters. One dose on 08/02/2023 was also noted as being missed due to being “too close to the previous dose,” but this exception was noted over an hour before (11:52am) the medication was scheduled for being administered (1:00pm). There was no indication that staff attempted to administer the medication within the time parameters of the order as written.

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 Lodge at Mallard's Landing 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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

09/20/2023

One Mallards Landing, LLC
The Lodge at Mallard's Landing
7083 Wagner Way NW
Gig Harbor, WA 98335

RE: The Lodge at Mallard's Landing # 2064

Dear Administrator:

The Department completed a complaint investigation of your Assisted Living Facility on 09/18/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Manfay Chan, Field Manager
Residential Care Services

Region 3, Unit D
PO Box 98250
Lakewood, WA 98496

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

Narcotic liquid medication (Oxycodone) belonging to one resident was found to have had a portion of the medication removed and replaced with water per staff observation. No harm resulted from this issue as the medication in question had not been used by the resident. Per facility staff, steps have been taken to ensure secure storage of narcotic medications, and for all narcotics to be delivered to the facility in tamper resistant and tamper evident packaging only (i.e. blister pack pill-form meds only). The evidence available did not rise to the level of a citation in regard to this issue.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

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:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services

Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

Enclosure