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) 39644 (Completion Date 04/11/2024) and 35807 (Completion Date 02/23/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/11/2024 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-2210-1-b

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 #: 35807
Investigator: Michael Goulet
Investigation Date(s): 01/25/2024 through 02/23/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 116004
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

1) Staff did not request a refill of resident's insulin, leading to the resident being without this medication for two days (from 1-21-24 to 1-22-24).
2) Resident refused insulin on 1-23-24 due to feeling unwell, and was sent to hospital for evaluation.

Investigation Methods:

Sample:	Total residents: Resident sample size: 3 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms
Interviews:	Residents Staff
Record Reviews:	Hospital Medical Records Facility Progress Notes Fax communication from facility to resident's physician Pharmacy packing list (noting delivery of medication to facility) Blood Glucose Log Medication Administration Records

Investigation Summary:

1,2) Per staff interviews and per record reviews of facility documentation, the named resident was not provided long acting (Lantus) insulin (42 units injected once each evening per medication orders) as ordered due to staff not ensuring that this medication was reordered in a timely manner. Per facility medication administration records, the resident only had 3 (three) units of long acting (Lantus) insulin remaining on the evening of 1-21-24, and was administered this amount, but the resident's orders specified 42 units of insulin to be given daily at this time. Per facility staff interviews and per record review of facility records, the named resident's long-acting insulin was not available as ordered at the facility on 1-21-24 and 1-22-24, and this

medication was not delivered to the facility until the morning of 1-23-24. When staff attempted to administer this medication on the evening of 1-23-24, the resident refused the medication, stating they were feeling unwell. The resident was transported to hospital that evening, and the resident's blood glucose reading on admit was noted to be significantly elevated at 341 (normal blood glucose range being between 70 and 126). Per record review of hospital medical records, the resident was noted to be experiencing hyperglycemia (high blood glucose) secondary to poorly controlled insulin dependent diabetes mellitus. Record review of the resident's medication administration records did note that that staff documented that the named resident was administered their long-acting insulin (Lantus) on the evening of 1-22-24, even though per other records and staff interviews this medication was not present in the facility at this time.
Interviews with other insulin dependent residents did not support that these residents had not been administered insulin as ordered, but this issue did raise a point of concern for the facility's medication services and the accuracy of staff documentation of administration.
Cited as per WAC 388-78A-2210 (1b) 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 #: 35807
Investigator: Michael Goulet
Provider Type: Assisted Living Facility
Intake ID: 116115
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 01/25/2024 through 02/23/2024
Complainant Contact Date(s): 01/29/2024, 02/26/2024

Allegation(s):
1) resident without insulin for three days due to facility forgetting to order medication

Investigation Methods:

Sample:	Total residents: Resident sample size: 3 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms
Interviews:	Residents Staff
Record Reviews:	Hospital Medical Records Facility Progress Notes Fax communication from facility to resident's physician Pharmacy packing list (noting delivery of medication to facility) Blood Glucose Log Medication Administration Records

Investigation Summary:
1) Per staff interviews and per record reviews of facility documentation, the named resident was not provided long acting (Lantus) insulin (42 units injected once each evening per medication orders) as ordered due to staff not ensuring that this medication was reordered in a timely manner. Per facility medication administration records, the resident only had 3 (three) units of long acting (Lantus) insulin remaining on the evening of 1-21-24, and was administered this amount, but the resident's orders specified 42 units of insulin to be given daily at this time. Per facility staff interviews and per record review of facility records, the named resident's long-acting insulin was not available as ordered at the facility on 1-21-24 and 1-22-24, and this medication was not delivered to the facility until the morning of 1-23-24. When staff attempted to administer this medication on the evening of 1-23-24, the resident refused the medication, stating they were feeling unwell. The resident was transported

to hospital that evening, and the resident's blood glucose reading on admit was noted to be significantly elevated at 341 (normal blood glucose range being between 70 and 126). Per record review of hospital medical records, the resident was noted to be experiencing hyperglycemia (high blood glucose) secondary to poorly controlled insulin dependent diabetes mellitus. Record review of the resident's medication administration records did note that staff documented that the named resident was administered their long-acting insulin (Lantus) on the evening of 1-22-24, even though per other records and staff interviews this medication was not present in the facility at this time. Interviews with other insulin dependent residents did not support that these residents had not been administered insulin as ordered, but this issue did raise a point of concern for the facility's medication services and the accuracy of staff documentation of administration.
Cited as per WAC 388-78A-2210 (1b) 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 98250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2064	Compliance Determination #35807
Plan of Correction	The Lodge at Mallard's Landing	Completion Date
Page 1 of 3	Licensee: One Mallards Landing, LLC	02/23/2024

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 01/25/2024 and 02/23/2024 of:

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

This document references the following complaint number(s): 116004, 116115

The following sample was selected for review during the unannounced on-site visit: 3 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 98250
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 — 02/27/2024 (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.

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

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The Lodge at Mallard's Landing
7083 Wagner Way NW
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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 _____ 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 #:35607
Plan of Correction	The Lodge at Mallard's Landing	Completion Date
Page 2 of 3	Licensee: One Mallards Landing, LLC	02/23/2024

Administrator (or Representative) 3-11-24 Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure that 1 of 3 residents (Resident 1[R1]) received their long-acting insulin as ordered due to not re-ordering this medication which led to the required dosage of medication not being available for three days. This failure placed the resident at risk of potential physical harm.

Findings included...

During an interview on 01/25/2024 at 10:10am, Staff A, facility Director of Nursing, stated that R1 had run out of Lantus (long-acting) insulin on 01/21/2024, having only three units available out of an ordered daily dosage of 42 units, and that R1's physician was notified of the need to re-order this medication on the same day (01/21/2024). Staff A stated that R1's Lantus insulin was delivered to the facility on 01/23/2024, but that R1 had refused this medication on 01/23/2024 due to feeling unwell. Staff A stated that R1 was evaluated by the facility staff after refusing this medication and noted to have a blood glucose reading over 500 (emergent; normal range 70-120) and was sent out to hospital for evaluation and treatment at this time.

Record review on 01/25/2024 at 2:00pm of facility progress notes and facility Medication Administration Record (MAR) showed that R1 was given the remaining amount, three units of long-acting insulin on the evening of 01/21/2024 instead of the ordered dose of 42 units.

Record review on 01/26/2024 at 2:00pm of facility fax communication sent by facility staff to R1's primary care physician on 01/21/2024 showed that the facility was out of Lantus (long-acting) insulin for R1 on 01/21/2024.

Record review on 01/25/2024 at 2:00pm of the Packing List provided to the facility from Costless Pharmacy showed that R1's Lantus insulin was not delivered to the facility until 01/23/2024 at 9:18am.

Administrator (or Representative) Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure that 1 of 3 residents (Resident 1[R1]) received their long-acting insulin as ordered due to not re-ordering this medication which led to the required dosage of medication not being available for three days. This failure placed the resident at risk of potential physical harm.

Findings included…

During an interview on 01/25/2024 at 10:10am, Staff A, facility Director of Nursing, stated that R1 had run out of Lantus (long-acting) insulin on 01/21/2024, having only three units available out of an ordered daily dosage of 42 units, and that R1's physician was notified of the need to re-order this medication on the same day (01/21/2024). Staff A stated that R1's Lantus insulin was delivered to the facility on 01/23/2024, but that R1 had refused this medication on 01/23/2024 due to 'feeling unwell'. Staff A stated that R1 was evaluated by the facility staff after refusing this medication and noted to have a blood glucose reading over 500 (emergent; normal range 70-126) and was sent out to hospital for evaluation and treatment at this time.

Record review on 01/25/2024 at 2:00pm of facility progress notes and facility Medication Administration Record (MAR) showed that R1 was given the remaining amount, three units of long-acting insulin on the evening of 01/21/2024 instead of the ordered dose of 42 units.

Record review on 01/25/2024 at 2:00pm of facility fax communication sent by facility staff to R1's primary care physician on 01/21/2024 showed that the facility was out of Lantus (long-acting) insulin for R1 on 01/21/2024.

Record review on 01/25/2024 at 2:00pm of the Packing List provided to the facility from Costless Pharmacy showed that R1's Lantus insulin was not delivered to the facility until 01/23/2024 at 9:18am.

Statement of Deficiencies	License #: 2064	Compliance Determination # 35807
Plan of Correction	The Lodge at Mallard's Landing	Completion Date
Page 3 of 3	Licensee: One Mallards Landing, LLC	02/23/2024

Record review on 01/25/2024 at 2:00pm of the facility MAR for R1 showed that Staff B, facility staff Med Tech, did document R1's Lantus insulin as being administered on the evening of 01/22/2024, even though (as supported by the above interview and records) this medication was not available in the facility at this time.

Record review on 02/20/2024 at 3:40pm of R1's hospital medical records showed that R1's blood glucose on admission to hospital (01/23/2024 at 9:08pm) was 341 (normal range 70-126), and that R1 was noted to be experiencing "Hyperglycemia (elevated blood glucose) secondary to poorly controlled insulin dependent diabetes mellitus."

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) 3/11/2024

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

Administrator (or Representative) — Date: 3/11/2024

Record review on 01/25/2024 at 2:00pm of the facility MAR for R1 showed that Staff B, facility staff Med Tech, did document R1's Lantus insulin as being administered on the evening of 01/22/2024, even though (as supported by the above interview and records) this medication was not available in the facility at this time.

Record review on 02/20/2024 at 3:40pm of R1's hospital medical records showed that R1's blood glucose on admission to hospital (01/23/2024 at 9:08pm) was 341 (normal range 70-126), and that R1 was noted to be experiencing “Hyperglycemia (elevated blood glucose) secondary to poorly controlled insulin dependent diabetes mellitus.”

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