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

Maplewood Gardens Assisted Living Community LLC
Maplewood Gardens Assisted Living
1100 North Superior Street
Spokane, WA 99202

RE: Maplewood Gardens Assisted Living License # 2470

Dear Administrator:

This letter addresses Compliance Determination(s) 66988 (Completion Date 10/09/2025) and 63821 (Completion Date 08/07/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/09/2025 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-2474-2-c, WAC 388-78A-2474-2-e, WAC 388-78A-2474-4

The Department staff who did the on-site verification:
Carla Rose, NCI Community 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

Statement of Deficiencies	License #: 2470	Compliance Determination # 63821
Plan of Correction	Maplewood Gardens Assisted Living	Completion Date
Page 1 of 3	Licensee: Maplewood Gardens Assisted Living Community LLC	08/07/2025

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 follow-up on 08/06/2025 and 08/07/2025 of:
Maplewood Gardens Assisted Living
1100 North Superior Street
Spokane, WA 99202

This document references the following SOD dated: 08/07/2025

The following sample was selected for review during the unannounced on-site visit: 6 of 190 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Carla Rose, NCI Community Licensor
Tethra Wales, Assisted Living Facility Licensor

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.

J Salquist
Residential Care Services

08/19/2025
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)

8/26/2025
Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(e) Continuing education.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff had completed the developmentally delayed specialty training course for 3 of 3 sampled staff (Staff O, P, and Q). This failed practice placed residents at risk due to receiving care from untrained staff.

Findings included...

Review of the characteristics roster dated 08/06/2025, showed four residents with a developmental disability (DD).

Review of Staff O's, Lead Medication Technician, personnel file showed they were hired on 08/08/2023. Further review showed no documentation of DD specialty training.

Review of Staff P's, Medication Technician, personnel file showed they were hired on 06/14/2023. Further review showed no documentation of DD specialty training.

Review of Staff Q's, Resident Care Coordinator, personnel file showed they were hired on 06/26/2023. Further review showed no documentation of DD specialty training.

Review of the staff schedule from 08/01/2025 – 08/07/2025 showed that Staff O worked two shifts, Staff P worked five shifts, and Staff Q worked four shifts.

In an interview on 08/06/2025 at 4:12 PM, Staff R, Human Resources, confirmed that Staff O, P, and Q did not have DD specialty training.

This is an uncorrected deficiency previously cited on 06/11/2025 (2)(c).

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, Maplewood Gardens Assisted Living is or will be in compliance with this law and / or regulation on
(Date) 10/02/2025

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

Administrator (or Representative)

8/26/2025
Date

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 and complaint investigation on 06/02/2025, 06/03/2025, 06/04/2025, 06/05/2025, 06/06/2025, 06/10/2025 and 06/11/2025 of:
Maplewood Gardens Assisted Living
1100 North Superior Street
Spokane, WA 99202

This document references the following complaint numbers: 180428.

The following sample was selected for review during the unannounced on-site visit: 22 of 184 current residents and 6 former residents.

The department staff that inspected the Assisted Living Facility:

Carla Rose, NCI Community Licensor
Jennifer Lee, Assisted Living Facility Licensor
Tethra Wales, Assisted Living Facility Licensor
Brian Zbylski, ALF Licensor

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 — 06/25/2025 (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) — 6/26/2025 (Date)

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;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that residents were treated with dignity and respect and that their rights were protected for 8 of 18 residents (Residents 3, 5, 6, 7, 9, 15, 24, and 25). This failure resulted in residents fearing eviction, feeling unsafe due to not getting a call pendant and feeling their privacy had been violated after staff entered their rooms unannounced to move or remove personal belongings, and placed the residents at risk for a decreased quality of life.

Findings included...

<Resident 3>

Review of Resident 3's face sheet showed that Resident 3 was admitted to the facility on [redacted]2024.

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.

Administrator (or Representative) | Date

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

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that residents were treated with dignity and respect and that their rights were protected for 8 of 19 residents (Residents 3, 5, 6, 7, 9, 15, 24, and 25). This failure resulted in residents fearing eviction, feeling unsafe due to not getting a call pendant and feeling their privacy had been violated after staff entered their rooms unannounced to move or remove personal belongings, and placed the residents at risk for a decreased quality of life.

Findings included…

<Resident 3>

Review of Resident 3's face sheet showed that Resident 3 was admitted to the facility on [redacted]/2024.

In an interview on 06/05/2025 at 9:19 AM, Resident 3 stated that “people here are very frightened.” Resident 3 stated that residents believed that if they voiced a concern they would be punished or moved.

In an interview on 06/10/2025 at 10:38 AM, Resident 3 stated, “there is a threat of fear that runs through here [the facility].” Resident 3 stated there was an incident when a staff person entered their room unannounced during the night and frightened their dog, causing the dog to bark. Resident 3 stated that the staff person stated to them, “If I had known you had an attack dog, I would never have let you in here,” and that “maybe we’re just not a good place for you.”

<Resident 5>

In an interview on 06/05/2025 at 3:04 PM, Resident 5 stated that staff had recently entered their room while they were away and removed their medications. The resident further stated that they received a letter from Staff F, Director of Nursing Services, stating that staff entered the resident’s room and removed their medications. Resident 5 stated that it felt like a “thief in the night,” and that they filed a written grievance with management that was never addressed .

In an interview on 06/05/2025 at 5:06 PM, Staff F stated that they entered Resident 5’s room and removed their medications and provided a letter informing the resident, after completing the task (without prior notice).

In an interview on 06/05/2025 at 5:06 PM, Staff I, Executive Director, stated that the expectation of staff prior to entering a resident’s room was to give notice to the residents and have two staff persons enter.

<Resident 6>

During the resident group meeting on 06/02/2025 at 2:00 PM, Resident 6 stated that due to a fall with an injury prior to their admission, they would have felt safer if they had a call pendant to keep with them. Resident 6 said when they requested the pendant from staff they were told, “you walk better than I do” and was not given a pendant.

Review of Resident 6’s admission paperwork showed a “Pendant Sign-Out” form, dated [redacted]/2023, the day of their admission. The form was signed by Resident 6 and a representative of the facility. At the top of the form was a handwritten note that said, “would like one.”.

In an interview on 06/05/2025 at 2:40 PM, Resident 6 said they requested a pendant when they moved in, they signed a form during their admission and never got a pendant. Resident 6 stated that after their admission, they asked two different staff

members for a pendant but did not get one. Resident 6 then stated that yesterday [06/04/2025] Staff H, Lead Housekeeper, and Staff L, Maintenance Manager, used their keys to enter Resident 6's room. Resident 6 said they had not given the two staff permission to enter their room, and they felt embarrassed because they were in the restroom at the time the staff entered. Resident 6 further stated that they removed items from the top shelf in their room and placed them on their bed.

<Resident 7>

In an interview on 06/05/2025 at 11:25 AM, Resident 7 stated that staff had entered their room while they were away on 06/04/2025. The resident stated that staff had moved boxes and containers of their belongings from a shelf to the floor and created a trip hazard. The resident further stated that they felt angry, and that staff did not respect their rights. Resident 7 stated that Staff H, Lead Housekeeper, informed them of what they had done after they had been in their room.

Observation on 06/05/2025 at 11:25 AM, showed multiple boxes and containers on the floor of Resident 7's room and an empty shelf over the storage area adjacent to resident's sleeping area.

In an interview on 06/04/2025 at 11:38 AM, Resident 7 stated that they received meal trays in their room for approximately two years due to noise and light sensitivity. Resident 7 stated that a month ago, Staff I, Executive Director, informed them that the facility would no longer be providing meal trays and that they would need to go down to the dining room to get their meals. Resident 7 further stated they felt like "If you can't then you are gone. It makes me feel less valued."

In an interview on 06/06/2025 at 11:24 AM, Staff F stated that the facility did not see delivered meal trays as "being very effective," and that they "do not provide as good of an experience." Staff F further stated that 15 people were taken off delivered meal trays, including Resident 7. Staff F stated that the administration team discussed "who's not socializing" and "who's not doing well," and made a list of residents to be removed from delivered meal trays.

<Resident 9>

In an interview on 06/04/2025 at 3:00 PM, Resident 9 stated that staff had entered their room while they were away earlier that day. The resident stated that staff had moved boxes and containers of their belongings from the top of the closet to the floor and placed these items in the walkway between the door to their bed. The resident further stated that they felt angry, and that staff did not respect their rights.

Observation on 06/04/2025 at 3:00 PM, showed multiple boxes and containers on the floor of Resident 9's room and an empty shelf over the closet between the resident's

door and their bed.

<Resident 15>

In an interview, on 06/06/2025 at 9:56 AM, Resident 15 stated that a couple months prior Staff J, Dietary Director, had entered their room while they were gone to look for dishes that belonged to the facility. The resident stated that they were not given an advance notice, and it felt “like I was invaded.” Resident 15 further stated that the incident prompted them to purchase a security camera for their room. Observation at that time showed a security camera directed towards the apartment entrance.

In an interview on 06/04/2025 at 2:25 PM, Staff H stated that they notified four residents about entering their apartments and removing items from the top shelf of their storage area, after the task had been completed (without prior notice).

In an interview on 06/06/2025 at 3:07 PM, Staff F stated that residents were to be notified prior to staff entering their rooms, staff were to enter in pairs and that typically staff did not enter unless the resident was home.

In an interview on 06/10/2025 at 10:03 AM, Staff L, Maintenance stated that staff would enter an unoccupied resident’s room to perform a task unless the resident had a sign on their door stating do not enter if the resident was not present.

<Resident 24>

In an interview, after the resident group meeting, on 06/02/2025 at 2:40 PM, Resident 24 requested to speak with department staff privately. Resident 24 reported that they were afraid to bring up concerns with the members of management for fear of being kicked out.

<Resident 25>

In an interview on 06/04/2025 at 2:55 PM, Resident 25 stated that “Staff F is hard as nails,” and was “horrible about threatening.” Resident 25 further stated that for several years they had been receiving laundry assistance three times a week due to incontinence (lack of voluntary control of urine and bowel) but were told by Staff F the facility would be moving to provide laundry assistance once a week. Resident 25 stated that they were then told by Staff F that if the facility could not meet their needs then they [the resident] may need to leave. Resident 25 then stated, “I don’t know why the need to threaten me with eviction was there” and threats of discharge happened more than they should.

This is a recurring citation previously cited on 07/28/2022 for subsection (1).

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, Maplewood Gardens Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7/25/2025

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

Administrator (or Representative) — Date: 6/26/2025

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.

(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:

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance, and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that a safe medication assistance system was implemented, and that residents received medications as prescribed for 3 of 16 residents (Residents 2, 12, and 23) sampled for medication services. This failure resulted in unsafe self-administration of medication for Resident 2, contributed to unmanaged blood sugars and falls for Resident 12 and not receiving medications as ordered by their primary care provider for Resident 23, and placed the residents at risk for health complications.

Findings included...

<Resident 12>

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, Maplewood Gardens Assisted Living 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

WAC 388-78A-2210 Medication services.

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(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 :

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This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that a safe medication assistance system was implemented, and that residents received medications as prescribed for 3 of 16 residents (Residents 2, 12, and 23) sampled for medication services. This failure resulted in unsafe self-administration of medication for Resident 2, contributed to unmanaged blood sugars and falls for Resident 12 and not receiving medications as ordered by their primary care provider for Resident 23, and placed the residents at risk for health complications.

Findings included...

<Resident 12>

Review of Resident 12's Service Plan Report (the facility's titled Negotiated Service Agreement, NSA) showed that Resident 12 was admitted to the facility on [redacted]/2023 and had a diagnosis of [redacted]. Further review showed that the facility would be responsible for ordering the resident's medication and assisted with Resident 12's medications and treatments.

- Low Blood sugars

Review of Resident 12's March 2025 progress notes showed an incident investigation, dated 03/13/2025, in which the resident fell and struck their head in the dining room. Further review showed that Resident 12's blood sugar (BS) taken at the time of the incident was 54 (normal blood sugar range is 70-100), that an emergency medical technician administered glucose jelly to raise their blood sugar level, and that the investigation determined that the incident was due to low blood sugar.

Review of an After Visit Summary (AVS), dated 04/20/2025, showed that the resident was seen at the emergency room and that the reasons for the visit were low blood sugar and a fall.

Review of an AVS, dated 04/17/2025, showed instructions for a hypoglycemia protocol detailing the administration of juice, soda or glucose tabs and additional blood sugar checks at 15-minute intervals when the resident's BS was below 70, and carbohydrate/protein snacks were to be given once the resident's BS was back above 70.

In an interview on 06/05/2025 at 4:14 PM, Staff F, Director of Nursing Services, confirmed that the hypoglycemia protocol was not included on the medication administration record (MAR) and should have been posted on the medication carts or in the medication rooms.

Observation on 06/05/2025 at 4:40 PM showed the medication carts on the third floor where the resident resided, did not have instructions regarding the hypoglycemia protocol.

In an interview on 06/05/2025 at 4:42 PM, Staff N, Medication Technician (MT), stated there were no instructions about snacks or additional blood sugar checks for Resident 12 on the cart or in the med room. Staff N further stated that they had been instructed to call the nurse anytime Resident 12's blood sugar was low.

Review of Resident 12's May 2025 MAR showed that the resident's BS was below 70 on 05/06/2025 (BS of 60 at 5:00 PM) and 05/28/2025 (BS 60 at 8:00 AM), with no additional

blood sugar readings documented.

Review of Resident 12's May 2025 progress notes showed an entry on 05/06/2025, that read "Low blood sugar reported to nurse; nurse instructed to give apple juice and send res[ident] to dinner. [Resident] agreed. Called and left message with dr [doctor]." Further review showed no additional blood sugar checks documented in the progress notes for 05/06/2025 and no notes documented on 05/28/2025.

In an interview on 06/10/2025 at 1:40 PM, Staff F stated they had no documentation to show that Resident 12's blood sugar was rechecked after it read below 70 on 05/06/2025 or 05/28/2025.

In an interview on 06/10/2025 at 11:20 AM, Resident 12 stated that the MT had just checked their blood sugar and that it was 68. When asked if staff had provided them with juice, Resident 12 stated that they did not.

- High blood sugars

Review of an administration progress note, dated 04/11/2024, showed instructions to call the doctor when Resident 12's blood sugar was over 400.

Review of Resident 12's March, April, and May 2025 MARs showed the resident's BS was above 400 on 03/06/2025 (467), 03/20/2025 (480), 03/25/2025 (474), 04/13/2025 (456), and 05/01/2025 (421).

In an interview on 06/10/2025 at 1:40 PM, Staff F confirmed that there were no documented communications with Resident 12's provider on 03/06/2025, 03/20/2025, 03/25/2025, 04/13/2025, or 05/01/2025.

- Lantus

Review of a provider visit note, dated 03/26/2025, showed a change to the instructions for Resident 12's Lantus (injectable long-acting insulin) with a start date of 03/26/2025. Further review showed that 32 units were to be injected every morning, with a decrease of 3 units every three days if the BS was less than 130.

Review of Residents 12's April 2025 and May 2025 MARs showed Resident 12's BS was below 130 for three days or more on the following dates:

04/10/2025 (111)
04/11/2025 (115)

04/12/2025 (86)
04/17/2025 (98)
04/18/2025 (92)
04/19/2025 (129)
04/20/2025 (84)
05/10/2025 (129)
05/11/2025 (123)
05/12/2025 (102)
05/13/2025 (104)
05/14/2025 (117)
05/16/2025 (91)
05/17/2025 (104)
05/18/2025 (82)
05/19/2025 (97)
05/20/2025 (89)
05/23/2025 (90)
05/24/2025 (86)
05/25/2025 (109)
05/26/2025 (103)
05/27/2025 (86)
05/28/2025 (60)
05/29/2025 (104)

Further review of the MARs showed that the Lantus was decreased by three units one time. The new dose of 29 units started on 04/23/2025.

In an interview on 06/06/2025 at 10:50 AM, Staff F stated that they were aware of the order and that they monitored Resident 12's blood sugar because the system used to track medication administration made it difficult. Staff F stated that they lowered the units by three on 04/23/2025. When asked about the stretches where the resident's BS was low for 3 or more days in April and May, Staff F stated they "probably missed it" and "didn't catch that." Staff F further stated that they were not sure where they were with the Lantus at the time of the interview and would look into it.

Insulin held in error

- Aspart

Review of Resident 12's April 2025 MAR showed an order for Aspart (a fast-acting injectable insulin that lowers blood sugar) to be given at 6:00 PM and to be held if the resident's BS was less than 60. Further review showed that on 04/01/2025, the 6:00 PM dose was held when the resident's BS was 76.

Review of Resident 12's May 2025 MAR showed orders for Aspart to be given at 8:00 AM and 12:00 PM, with no parameters to hold the medication included in the order. Further review showed that Aspart was held in error on 03/06/2025, 05/01/2025, 05/07/2025,

05/19/2025, and 05/28/2025.

In an interview on 06/05/2025 at 4:14 PM, Staff F stated that on the dates noted, the medication was held in error.

- Glargine

Review of Resident 12's March 2025 MAR showed an order for glargine (long-acting injectable insulin) to be injected every morning. Further review showed that it was held on 03/06/2025 and 03/20/2025.

In an interview on 06/05/2025 at 4:14 PM, Staff F stated that there were no parameters to hold the medication and that it was held in error.

In an interview on 06/06/2025 at 10:50 AM, Staff F stated they audited the MARS for refusals, missed medications and non-available medications daily but that audits for outside of parameters or other exceptions or administration errors did not occur on a consistent basis.

- Zegalogue

Review of Resident 12's April 2025 and May 2025 MARs showed an order for Zegalogue (glucagon, a glucose elevating agent used to treat very low blood sugar) to be given by injection as needed. Further review showed no instructions or parameters for use to include when the medication should be given and who should administer it.

In an interview on 06/05/2025 at 4:14 PM, Staff F stated they were unaware that the MAR did not include instructions for the Zegalogue and would look into it. Staff F further stated that they were unsure where it was kept or if it was delivered.

Observation on 06/06/2025 at 10:10 AM showed Zegalogue in the refrigerator in the 3rd floor medication room.

<Resident 2>

Review of Resident 2's NSA, dated 04/09/2025, showed that "Resident is able to keep certain medications at bedside for self-administration… [Resident 2] will manage some of [their] own OTC (over the counter medication)." Further review showed the NSA had been signed by Staff F, Staff G, Social Services Director and Resident 2.

Review of a Medication Self Administration assessment, dated 03/01/2025, showed that Resident 2 was “unable to safely self- administer medications.”

In an interview and observation on 06/03/2025 at 2:50 PM, Resident 2 stated that they managed some of their own medications and kept them in their room. Resident 2 then showed the department the OTC medications they had in their room which included vitamin D, fish oil, magnesium oxide, vitamin B12, lidocaine patches (pain relief patches), and acetaminophen (Tylenol pain reliever). Resident 2 then stated that they took the medications daily. Resident 2 further stated that they took the acetaminophen each day between 12 PM and 2 PM.

Review of Resident 2’s April 2025 and May 2025 MARs showed that Resident 2 was prescribed acetaminophen, and it had been administered by medication technicians at 8:00 AM, 12:00 PM, and 9:00 PM each day. Further review showed hydrocortisone cream (anti-itch cream), magnesium gluconate (supplement), and vitamin B12 were listed as “U-SA” (unsupervised self-administration).

In an interview on 06/03/2025 at 2:10 PM, Staff F stated that Resident 2 should not have kept medications in their room once the self-medication assessment was changed. Staff F was unsure why the NSA and MARs showed that Resident 2 still self-administered medications.

<Resident 23>

Review of Resident 23’s NSA, dated 09/12/2024, showed the resident had diagnoses of [redacted] and [redacted] and required assistance with ordering medications.

Review of a primary care provider (PCP) letter, dated 06/03/2025 and addressed to the facility, showed that Resident 23 was to begin taking hydrochlorothiazide (medication used to treat high blood pressure and fluid retention) daily.

Review of Resident 23’s June 2025 MAR showed it did not contain an order for hydrochlorothiazide.

In an interview on 06/10/2025 at 11:00 AM, Resident 23 stated that their PCP had ordered a medication to treat water retention about one week prior and that they had not been receiving the medication. The resident further stated that their legs became painful when too much fluid accumulated and that they had to lay down or elevate their legs to get relief.

In an interview on 06/11/2025 at 11:40 AM, Staff F stated that they were not aware of the PCP letter with directions to start the hydrochlorothiazide on 06/03/2025 and that

reception of the fax may have been missed due to a facility fax system maintenance issue that occurred about that time. Staff F acknowledged that Resident 23 had not received the medication.

This is a recurring deficiency previously cited on 02/07/2024, 08/07/2023, and 07/28/2022.

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, Maplewood Gardens Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7/25/2025

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

Administrator (or Representative) — Date: 6/26/2025

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide a communication system in the corridors for 3 of 3 resident buildings (Building A, B, and C). This failure placed residents at risk of harm due to not being able to summon staff in the event of an emergency.

Findings included...

Observation during the environmental tour on 06/02/2025 at 9:20 AM, showed that the corridors residents traversed through in Buildings A, B, and C, did not have any communication systems on any of the four floors.

In an interview on 06/04/2025 at 4:20 PM, Staff I, Executive Director, confirmed that

reception of the fax may have been missed due to a facility fax system maintenance issue that occurred about that time. Staff F acknowledged that Resident 23 had not received the medication.

This is a recurring deficiency previously cited on 02/07/2024, 08/07/2023, and 07/28/2022.

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, Maplewood Gardens Assisted Living 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

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

(iii) Corridors, as well as common and outdoor areas accessible to residents.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide a communication system in the corridors for 3 of 3 resident buildings (Building A, B, and C). This failure placed residents at risk of harm due to not being able to summon staff in the event of an emergency.

Findings included…

Observation during the environmental tour on 06/02/2025 at 9:20 AM, showed that the corridors residents traversed through in Buildings A, B, and C, did not have any communication systems on any of the four floors.

In an interview on 06/04/2025 at 4:20 PM, Staff I, Executive Director, confirmed that

resident corridors in Buildings A, B, and C did not have a communication system.

Review of a resident list provided to the department on 06/03/2025, showed that 78 out of 184 residents did not have a call pendant to summon for assistance.

In an interview on 06/10/2025 at 11:00 AM, Staff I acknowledged that not all residents had a call pendant, and they needed to purchase more.

During the resident group meeting on 06/02/2025 at 2:00 PM, Resident 8 stated that due to a fall with an injury prior to their admission, they would have felt safer if they had a call pendant to keep with them.

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, Maplewood Gardens Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7/25/2025.

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

Administrator (or Representative) — Date: 6/26/2025

WAC 388-78A-2170 Required assisted living facility services.

(2) The assisted living facility must provide each resident with the following basic services, consistent with the resident's assessed needs and negotiated service agreement:

(e) Nutritious snacks - Providing nutritious snack items on a scheduled and nonscheduled basis, and providing nutritious snacks in accordance with WAC 388-78A-2300 .

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide snacks to residents that were not diabetic for 4 of 15 sampled residents (Residents 1, 3, 7, and 15). This failure resulted in residents not having access to food between meals and having to purchase their own snacks, and placed the residents at risk for malnourishment.

resident corridors in Buildings A, B, and C did not have a communication system.

Review of a resident list provided to the department on 06/03/2025, showed that 78 out of 184 residents did not have a call pendant to summon for assistance.

In an interview on 06/10/2025 at 11:00 AM, Staff I acknowledged that not all residents had a call pendant, and they needed to purchase more.

During the resident group meeting on 06/02/2025 at 2:00 PM, Resident 6 stated that due to a fall with an injury prior to their admission, they would have felt safer if they had a call pendant to keep with them.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2170 Required assisted living facility services.

(2) The assisted living facility must provide each resident with the following basic services, consistent with the resident's assessed needs and negotiated service agreement:

(e) Nutritious snacks - Providing nutritious snack items on a scheduled and nonscheduled basis, and providing nutritious snacks in accordance with WAC 388-78A-2300 .

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide snacks to residents that were not diabetic for 4 of 15 sampled residents (Residents 1, 3, 7, and 15). This failure resulted in residents not having access to food between meals and having to purchase their own snacks, and placed the residents at risk for malnourishment.

Findings included...

<Resident 1>

In an interview on 06/04/2025 at 1:50 PM, Resident 1 stated that they had to buy their own snacks because there were none available outside of mealtimes.

Review of Resident 1's Service Plan Report (the facility's titled Negotiated Service Agreement, NSA), dated 07/15/2024, showed the resident kept snacks in their apartment.

<Resident 3>

In an interview on 06/05/2025 at 9:19 AM, Resident 3 stated that they do not have access to food outside of meals. Resident 3 further stated that they cannot ask for a snack and "that's why the [resident] store is so successful."

<Resident 7>

In an interview on 06/05/2025 at 11:25 AM, Resident 7 stated that they had been denied snack requests by caregivers, but sandwiches were available for residents with diabetes (condition in which the body cannot properly regulate blood sugar levels). The resident further stated that they or their family had purchased food which they kept in their refrigerator. Observation at that time showed the resident's refrigerator and freezer contained sausage, eggs, yogurt and prepared meals.

Review of Resident 7's NSA, dated 06/04/2025, showed the resident kept snacks in their apartment.

<Resident 15>

In an interview on 06/06/2025 at 9:56 AM, Resident 15 stated that they had to buy their own snacks unless they were diabetic and that when they had requested snacks in the past, they were told by staff that there were no snacks available.

Review of Resident 15's NSA, dated 07/30/2024, showed the resident kept snacks in their apartment.

Review of an admissions packet, dated 05/26/2022, provided to the department during the inspection, showed a form titled "Exhibit 1 Basic Services and Rates." The form

listed "three meals daily, snacks and beverages" as part of their basic services provided.

Observation during the environmental tour on 06/02/2025 at 9:50 AM, showed a resident store. The room contained various snack items, supplies, and homemade trinkets. The items in the resident store were available for residents to purchase.

In an interview on 06/06/2025 at 9:55 AM, Staff K, Server, was asked what they did when a resident requested a snack. Staff K stated that they were trained to tell residents about the "resident store" where they could purchase snacks.

In an interview on 06/06/2025 at 10:03 AM, Staff J, Dietary Director, stated that they placed orders when snacks needed to be restocked. Staff J said the snacks were for diabetic residents and they were unsure if other residents could get snacks.

In an interview on 06/06/2025 at 10:30 AM, Staff F, Director of Nursing Services, was asked about snacks for all residents. Staff F stated that they "try to discourage it, they're mostly for diabetics." Staff F further stated that sometimes staff bought snacks for residents from the employee breakroom.

Plan/Attestation Statement

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

Administrator (or Representative) — 6/26/2025 Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120:

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

listed “three meals daily, snacks and beverages” as part of their basic services provided.

Observation during the environmental tour on 06/02/2025 at 9:50 AM, showed a resident store. The room contained various snack items, supplies, and homemade trinkets. The items in the resident store were available for residents to purchase.

In an interview on 06/06/2025 at 9:55 AM, Staff K, Server, was asked what they did when a resident requested a snack. Staff K stated that they were trained to tell residents about the “resident store” where they could purchase snacks.

In an interview on 06/06/2025 at 10:03 AM, Staff J, Dietary Director, stated that they placed orders when snacks needed to be restocked. Staff J said the snacks were for diabetic residents and they were unsure if other residents could get snacks.

In an interview on 06/06/2025 at 10:30 AM, Staff F, Director of Nursing Services, was asked about snacks for all residents. Staff F stated that they “try to discourage it, they’re mostly for diabetics.” Staff F further stated that sometimes staff bought snacks for residents from the employee breakroom.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to update service agreements when there was a change in condition for 2 of 15 sampled residents (Resident 2 and 5). This failure placed residents at risk of harm due to not having updated service agreement information available to staff and residents.

Findings included…

<Resident 2>

Review of Resident 2's Service Plan Report (the facility's titled Negotiated Service Agreement, NSA), dated 04/09/2025, showed that "Resident is able to keep certain medications at bedside for self-administration… [Resident 2] will manage some of [their] own OTC (over the counter medications)." Further review showed the NSA had been signed by Staff F, Director of Nursing Services, Staff G, Social Services Director, and Resident 2.

Review of a Medication Self Administration assessment for Resident 2, dated 03/01/2025, showed that Resident 2 was "unable to safely self-administer medications."

In an interview and observation on 06/03/2025 at 2:50 PM, Resident 2 stated that they managed their own OTC medications and kept them in their room. Resident 2 was unaware that they were no longer allowed to manage their OTC medications. Resident 2 then showed the department the OTC medications they had in their room.

In an interview on 06/03/2025 at 2:10 PM, Staff F stated that Resident 2 was not safe to manage any of their medications. Staff F was unsure why the NSA had not been updated.

<Resident 5>

Review of Resident 5's NSA, dated 11/25/2024, showed that the resident was able to keep certain medications in their room for self-administration.

Review of Resident 5's Medication Self-Administration assessment, dated 04/18/2025, stated that the resident was unable to safely self-administer medications due to a recent suicide attempt by medication overdose.

In an interview on 06/05/2025 at 3:04 PM, Resident 5 stated that staff provided medication assistance to them, and that their medications were not kept in their room any longer.

In an interview on 06/05/2025 at 5:06 PM, Staff F confirmed that Resident 5 was no longer safe to keep medications in their room and that the medications had been removed from the resident's room.

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, Maplewood Gardens Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7/25/2025

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

Administrator (or Representative) — Date: 6/26/2025

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that areas of the kitchen were sanitary in 1 of 1 kitchen (Facility Kitchen). This failure placed residents at risk of foodborne illnesses.

Findings included...

On 06/03/2025 at 11:00 AM, during the food service/kitchen tour, the following was observed:

- A drain underneath the serving counter was surrounded by a layer of black build up, nine plastic bread bag clips and a slice of bread.

- The floor behind the stove, between the fryer and a large column, had a used glove on the floor and was covered in dirt, dust, and grease.

- The channel surrounding the cold-holding inset on the serving counter contained

In an interview on 06/05/2025 at 5:06 PM, Staff F confirmed that Resident 5 was no longer safe to keep medications in their room and that the medications had been removed from the resident's room.

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, Maplewood Gardens Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____ .

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure that areas of the kitchen were sanitary in 1 of 1 kitchen (Facility Kitchen). This failure placed residents at risk of foodborne illnesses.

Findings included…

On 06/03/2025 at 11:00 AM, during the food service/kitchen tour, the following was observed:

- A drain underneath the serving counter was surrounded by a layer of black build up, nine plastic bread bag clips and a slice of bread.

- The floor behind the stove, between the fryer and a large column, had a used glove on the floor and was covered in dirt, dust, and grease.

- The channel surrounding the cold-holding inset on the serving counter contained

broken tortilla chips, dried spiral macaroni, corn flakes and other food debris.

- The two shelves that were the length of the table, under the cold-holding inset, were wiped with a paper towel by a department staff, and showed a brown/grey film and food particles. A compressor (the electric motor used to power the cold holding table) installed on the bottom shelf was covered in grease and dust.

- Dust covered the side of the ice machine, the wall behind the ice machine, four vents in the ceiling above the food preparation table, two vents in the ceiling above the ice machine, along the outside of ventilation ducts and along the electrical conduits.

- A metal trash can lid leaning against the column next to the mixer was covered in dust and did not match any of the trash cans in the kitchen.

- The side of the stove facing the fryer had a buildup of grease and food debris running from the front to the back of the stove.

- A standing fan with a buildup of lint and debris in the blades was blowing in the direction of the serving counter and stove.

-The wall behind the magnetic knife holder had food splatter marks scattered over it.

-The floor by the pots and pans shelves had standing water puddled in the walkway toward the ice machine but not under the ice machine.

- The microwave had splatters of liquid and food debris inside.

- The mini-fridge with a glass door, next to the hot holding table, had smears on the glass and a large amount of food particles inside.

In an interview on 06/03/2025 at 10:30 AM, Staff J, Dietary Director, was asked if they had a deep cleaning schedule that staff followed. Staff J showed the department a list titled “Extra Cleaning Tasks,” and said that staff worked from that list monthly but did not document when each task was completed.

Observation on 06/03/2025 at 10:30 AM, showed a list titled “Extra Cleaning Tasks” hanging on the wall in the kitchen breakroom. The task list showed areas of the kitchen that were to be cleaned each week over the course of a month. The list did not have any dates and did not include any documentation to indicate that any tasks had been completed. The assigned staff names had been crossed off the list.

In an interview on 06/03/2025 at 11:20 AM, Staff M, Cook, stated that each position in the kitchen had a different list assigned for deep cleaning duties and the cleaning schedules were a work in progress. Staff M showed the department the "Extra Cleaning Tasks" list and said those tasks were assigned to certain staff in the kitchen and there was another list for other staff, but they were unsure where it was kept. Staff M stated that they did not track what tasks were completed. Staff M further stated that they tried to deep clean areas when they saw that it needed to be done.

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, Maplewood Gardens Assisted Living is or will be in compliance with this law and / or regulation on (Date) 7/25/2025

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

Administrator (or Representative) 6/26/2025 Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff received a first step tuberculosis test within three days of employment, and a second step tuberculosis test within one to three weeks after the first test, for 3 of 5 sampled staff (Staff A, B, and C). This failure placed residents at risk for exposure to tuberculosis infection.

Findings included...

<Staff A>

Review of the facility's staff list showed that Staff A, Caregiver, was hired on

In an interview on 06/03/2025 at 11:20 AM, Staff M, Cook, stated that each position in the kitchen had a different list assigned for deep cleaning duties and the cleaning schedules were a work in progress. Staff M showed the department the “Extra Cleaning Tasks” list and said those tasks were assigned to certain staff in the kitchen and there was another list for other staff, but they were unsure where it was kept. Staff M stated that they did not track what tasks were completed. Staff M further stated that they tried to deep clean areas when they saw that it needed to be done.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff received a first step tuberculosis test within three days of employment, and a second step tuberculosis test within one to three weeks after the first test, for 3 of 5 sampled staff (Staff A, B, and C). This failure placed residents at risk for exposure to tuberculosis infection.

Findings included…

<Staff A>

Review of the facility's staff list showed that Staff A, Caregiver, was hired on

07/26/2024.

Review of Staff A's undated personnel file showed it did not contain any documentation of two-step tuberculosis (TB, a communicable respiratory disease) testing completed upon hire, or within twelve months prior to employment.

In an interview on 06/10/2025 at 2:30 PM, Staff I, Executive Director, stated that they were unable to provide any documentation of TB tests for Staff A.

<Staff B>

Review of the facility's staff list showed that Staff B, Medical Technician (MT), was hired on 07/03/2024.

Review of Staff B's undated personnel file showed the first step TB test was placed on 09/27/2024 and read on 09/30/2024. Further review showed the second step was placed on 10/18/2024 and read on 10/20/2024.

In an interview on 06/11/2025 at 2:30 PM, Staff F stated that a first step TB test was initiated at time of hire for Staff B. Staff F further stated that a second test was not completed, and they had to initiate the two-step process again. Staff F confirmed the documentation previously provided represented the only complete two-step process for Staff B.

<Staff C>

Review of the facility's staff list showed that Staff C, MT, was hired on 01/25/2024.

Review of Staff C's undated personnel file showed the first step TB test was placed on 01/25/2024 and read on 01/27/2024. Further review showed the second step was placed on 3/14/2024 and read on 03/17/2024, seven weeks after hiring.

In an interview on 06/11/2025 at 11:03 AM, Staff I stated that they were unable to provide any additional documentation of TB tests for Staff C.

Plan/Attestation Statement

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

Administrator (or Representative) 6/26/2025 Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(e) Continuing education.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that specialty training was completed by 2 of 5 sampled staff (Staff B and C), that 12 units of approved continuing education units were completed by 2 of 5 staff (Staff C and E), and the home-care aide certification was obtained for 1 of 5 staff (Staff A). This failure placed residents at risk of receiving care from untrained care staff.

Findings included...

<Specialty Training>

Review of the Characteristic Roster, dated 05/15/2025, identified four residents (Resident 12, 26, 27, and 28) with a developmental disability (DD), 27 residents with [redacted] diagnoses, and ten residents with dementia (memory loss).

Review of Staff B's, Medical Technician (MT), personnel file showed they were hired on 07/03/2024. Further review showed no documentation of mental health, dementia, or

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(e) Continuing education.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that specialty training was completed by 2 of 5 sampled staff (Staff B and C), that 12 units of approved continuing education units were completed by 2 of 5 staff (Staff C and E), and the home-care aide certification was obtained for 1 of 5 staff (Staff A). This failure placed residents at risk of receiving care from untrained care staff.

Findings included…

<Specialty Training>

Review of the Characteristic Roster, dated 05/15/2025, identified four residents (Resident 12, 26, 27, and 28) with a developmental disability (DD), 27 residents with [redacted] diagnoses, and ten residents with dementia (memory loss).

Review of Staff B's, Medical Technician (MT), personnel file showed they were hired on 07/03/2024. Further review showed no documentation of mental health, dementia, or

DD specialty training.

Review of Staff C's, MT, personnel file showed they were hired on 01/25/2024. Further review showed no documentation of specialty training for dementia, mental health, or DD.

In an interview on 06/11/2025 at 11:03 AM, Staff I, Executive Director, confirmed that Staff B and C did not have the specialty training courses for mental health, dementia, and DD.

<Continuing Education Units>

Review of Staff C's personnel file showed they did not have approved Department of Social and Health Services (DSHS) continuing education credits.

Review of Staff E's, MT, personnel file showed they were hired 08/09/2021. Further review showed they did not have approved DSHS continuing education credits.

In an interview on 06/10/2025 at 3:10 PM, Staff I stated that they provided continuing education to staff in-house. Staff I confirmed that the curriculum and instructors had not been approved through the DSHS.

<Home Care Aide certification>

Review of Staff A's, Caregiver, personnel file showed they were hired on 07/26/2024 and their home-care aide certification (HCA) was pending as of 06/10/2025.

In an interview on 06/11/2025 at 11:03 AM, Staff I, confirmed that Staff A did not have their home-care aide certification, and they were unsure if Staff A had taken the test.

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Administrator (or Representative) — Date: 6/26/2025

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Administrator (or Representative) Date

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

Maplewood Gardens Assisted Living Community LLC
Maplewood Gardens Assisted Living
1100 North Superior Street
Spokane, WA 99202

RE: Maplewood Gardens Assisted Living # 2470

Dear Administrator:

This document references the following complaint numbers 180428.

The Department completed a full inspection and complaint investigation of your Assisted Living Facility on 06/11/2025 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 many deficiency listed on the enclosed report; and
- May inspect your program 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 Return the Plan/Attestation Statement and report with signatures to:

Stephanie Jenks, Community Field Manager
Residential Care Services

Region 1, Unit B
Preferred methods:
eFax: (509) 921-2426
Email: rcsregion1email@dshs.wa.gov
Optional method:
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

• 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-2690 Electronic monitoring equipment Resident requested use.

(5) The release of audio or video monitoring recordings by the facility is prohibited. Each person or organization with access to the electronic monitoring must be identified in the resident's negotiated service agreement.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

The facility had residents with video cameras in their rooms. The facility had not obtained written consent from the residents or the residents' representative and had not identified the monitoring in the negotiated service agreements. The facility took action and obtained written consents and added the electronic monitoring to their service agreements prior to conclusion of the inspection.

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;

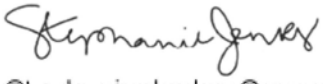
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o Send your request to:

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

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

Enclosure