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) 29899 (Completion Date 09/21/2023) and 27673 (Completion Date 08/07/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/21/2023 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-2210-1-b, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Sylvia Shauvin, Complaint Investigator

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

Sincerely,

S. Jm

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Maplewood Gardens Assisted Living
License/Cert.#: 2470
Compliance Determination #: 27673
Investigator: Sylvia Shauvin
Provider Type: Assisted Living Facility
Intake ID: 90622
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/04/2023 through 08/07/2023
Complainant Contact Date(s): 07/24/2023, 08/04/2023

Allegation(s):

1 - Medication omission(s)
2 - Facility took medication(s) away from resident
3 - Lack of assistance to arrange appointments
4 - Grievances aren't addressed, difficulty reaching staff by phone

Investigation Methods:

Sample:	Total residents: 190 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents' safety and well-being Staff's response to residents' needs and concerns Medication services
Interviews:	Four residents Resident's representative Two case managers Medication aide Resident Care Coordinator (RCC) Facility social services staff Administrator
Record Reviews:	Sample residents' Face Sheets, assessments, care plans, Progress Notes, and medication administration records (MARS) Sample three staff's credentials

Investigation Summary:

1 - Three sample residents interviewed had no concerns about medication services. A representative of one resident stated the resident was recently upset over not receiving several doses of medication(s). One sample resident stated staff sometimes did not provide their medications, but was unable to elaborate. Interview with RCC and review of MARS showed medication aides did not give two sample residents' medications, as ordered. Failed facility practice was found and documented in Statement of Deficiencies under Washington Administrative Code 388-78a-2210(1)(b)(2)(a) Medication services.

2 - Residents interviewed had no concerns about staff taking their medications away from them. Facility had a system for evaluating residents' ability to independently manage medications. The system included facility consulting with prescribers to obtain orders for residents to independently store and manage medications in their apartments. Facility formerly had prescriber's orders for one sample resident to independently manage/store over-the-counter supplements. When resident opted to no longer use the supplements, the order was discontinued. Investigation findings did not support failed facility practices related to the allegation.
3 - Residents interviewed had no concerns regarding appointments. Sample residents' care plans showed facility negotiated expectations regarding appointments with residents/representatives. During investigation, facility was in the process of setting up a requested medical appointment for a sample resident. Investigation findings did not support failed facility practices/warrant citation related to allegation.
4 - Information about how residents/visitors could reach staff outside of regular hours was posted at entrance and in lobby. Residents interviewed had no concerns about access to staff to address needs/concerns. Interviews with staff showed facility experienced some phone issues, and was in the process of acquiring a new phone system. Investigation findings did not support failed facility practices/warrant citation. Technical assistance was provided to facility regarding WAC 388-78a-2560(5)(a) Administrator responsibilities, regarding accessibility of staff at all times, including via phone, to address residents needs/concerns.

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: Maplewood Gardens Assisted Living
License/Cert.#: 2470
Compliance Determination #: 27673
Investigator: Sylvia Shauvin
Provider Type: Assisted Living Facility
Intake ID: 91970
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/04/2023 through 08/07/2023
Complainant Contact Date(s): 08/03/2023, 08/07/2023

Allegation(s):
1 - Medication omissions

Investigation Methods:

Sample:	Total residents: 190 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents' safety and well-being Staff's response to residents' needs and concerns Medication services
Interviews:	Four residents Resident's representative Two case managers Medication aide Resident Care Coordinator (RCC) Facility social services staff Administrator
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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 an unannounced on-site complaint investigation on 08/04/2023, 08/04/2023 and 08/04/2023 of:

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

This document references the following complaint number(s): 90622, 92207, 91970

The following sample was selected for review during the unannounced on-site visit: 3 of 190 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sylvia Shauvin, Complaint Investigator

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

08/11/2023
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.

Administrator (or Representative)

8/21/2023
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.

(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 provide medications as ordered for 2 of 3 residents (Residents 1 and 2). This failure placed the residents at risk of not having relief of symptoms, such as pain/discomfort.

Findings included...

<Resident 1>

Review of an entry dated 06/13/2022, in the Negotiated Services Agreement (NSA) for Resident 1 showed they had shoulder pain, and used ice, topical treatments, and medications for it. Medication services interventions updated on 08/17/2022 in the NSA showed the resident needed staff's assistance with some of their medications.

Review of Resident 1's June 2023 Medication Administration Record (MAR) showed staff needed to apply buprenorphine (narcotic pain medication) 20 micrograms(mcg)/hour patch, for pain, weekly every Friday after the old patch was removed. The order for buprenorphine was dated 03/17/2023.

Review of Resident 1's June and July 2023 MARS showed that the resident did not receive the buprenorphine patch on 06/23/2023, 06/30/2023, 07/07/2023, 07/14/2023, and 07/21/2023 and was documented as "not available".

As observed on 08/04/2023 at 10:00 AM, Resident 1 needed staff's assistance to apply the buprenorphine patch.

In an interview on 08/04/2023 at 11:55 AM, Staff A, Resident Care Coordinator (RCC), stated Resident 1 had chronic pain in their shoulders. Staff A stated they were aware of the omissions of the resident's buprenorphine patch in June 2023 and July 2023. Staff A stated the pharmacy delivered a box containing four patches at a time, and medication aides were supposed to alert the RCC when there was only one patch left in the box so more could be obtained. Regarding the June 2023 and July 2023 omissions of the buprenorphine patches, Staff A stated medication aides did not notify them until 07/21/2023 that more patches were needed for Resident 1.

In an interview on 08/04/2023 at 10:05 AM, Resident 1 stated there had been times when they did not receive their medications. Resident 1 further stated, "I don't feel great."

<Resident 2>

Review of an update in Resident 2's NSA, dated 08/23/2023, showed the resident needed staff assistance with medication.

Review of Resident 2's June 2023 MAR showed an order, dated 11/17/2022, for finasteride (medication to treat urinary retention) 5 milligrams at bedtime, and an order, dated 11/16/2022, for tamulosin (medication used to treat urinary retention related to an enlarged prostate) 0.4 mgs two capsules at bedtime.

Review of Resident 2's July 2023 MAR showed the resident did not receive tamulosin on 07/18/2023, 07/19/2023, and 07/20/2023 because the medication was "not available".

In an interview on 08/04/2023 at 4:30 PM Collateral Contact 1 (CC1), Resident 2's representative, stated the resident called them to say they were upset that they did not receive their medication to treat the prostate problem.

In an interview on 08/07/2023 at 7:15 AM, Staff A stated they were unaware of the omissions of tamulosin in July 2023. Staff A stated that the staff did not notify them about the unavailability of tamulosin.

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) 9/20/2023.

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

Administrator (or Representative) — Date: 8/21/2023