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) 38429 (Completion Date 03/26/2024) and 35081 (Completion Date 02/07/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/26/2024 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, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Raul Gatchalian, Community Complaint Investigator

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

Sincerely,

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 #: 35081
Investigator: Raul Gatchalian
Investigation Date(s): 01/12/2024 through 02/07/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 112724
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):
Medication error.

Investigation Methods:

Sample:	Total residents: 182 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms Medication administration Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members Director of Nursing Medication aide
Record Reviews:	Medical records State reporting log Incident investigation Facility policies Staff training records Staff patterns

Investigation Summary:
Facility records showed that the identified resident did not receive their medication for a long period of time. Facility failed to follow their medication policy. Failed facility practice cited under WAC 388-76A-2210 (1)(b).

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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AGING AND LONG-TERM SUPPORT ADMINISTRATION

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2470	Compliance Determination # 35081
Plan of Correction	Maplewood Gardens Assisted Living	Completion Date
Page 1 of 3	Licensee: Maplewood Gardens Assisted Living Community LLC	02/07/2024

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 01/12/2024, 01/12/2024 and 01/12/2024 of:

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

This document references the following complaint number(s): 112724, 113083, 111340, 113980, 116341

The following sample was selected for review during the unannounced on-site visit: 6 of 182 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Raul Gatchalian, Community 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.

S. M

Residential Care Services

02/20/2024

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.

Administrator (or Representative)

2/26/2024
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.

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 :

(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 interview and record review, the facility failed to ensure a new medication order was processed and administered as prescribed for 1 of 6 residents (Resident 1). These failures resulted in Resident 1 not receiving their medication for an extended period of time and placed the resident at risk of health complications.

Findings include...

Review of facility's policy titled, "Medication Ordering and Delivery," dated 05/26/2021, showed that when a medication is received by the facility, the medication needs to be transcribed onto the medication administration record (MAR).

Review of Resident 1's care plan, dated 02/01/2023, showed that the facility assisted with medication administration.

Review of Resident 1's incident report, dated 12/29/23 at 10:13 AM, showed that Resident 1 received an order for Eliquis (medication used to prevent blood clots) on 12/12/2023. Further review of the incident report showed the resident did not receive the Eliquis until 12/31/2023, 20 days after it was ordered to begin.

Review of Resident 1's December 2023 (MAR) showed documentation that Eliquis was not administered until 12/31/2023 at 08:00 AM.

Review of Resident 1's progress note, dated 01/02/2024 at 11:46 AM, showed that

Resident 1's medication was not administered as ordered as it was not transcribed onto the MAR and was placed in an overflow drawer.

Review of Resident 1's progress note, dated 01/02/2024 at 3:31 PM, showed that the Eliquis was received but the order was not transcribed onto the electronic MAR.

In an interview on 01/12/2024 at 11:00 AM, Staff A, Director of Nursing, stated that Resident 1's Eliquis was delivered on time. Staff A further stated the medication aides did not notify the nurse about the missing order in the electronic MAR.

This is a recurring deficiency previously cited on 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) 3/1/2024.

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

Administrator (or Representative)

2/26/2024

Date