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) 51589 (Completion Date 12/30/2024) and 48960 (Completion Date 10/25/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/30/2024 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-2240

The Department staff who did the on-site verification:
Amy Wright, NCI Complain Investigator

If you have any questions, please contact me at (509)323-7315.

Sincerely,

J Salquist

Jessica Salquist, 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 # 48960
Plan of Correction	Maplewood Gardens Assisted Living	Completion Date
Page 1 of 3	Licensee: Maplewood Gardens Assisted Living Community LLC	10/25/2024

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 follow-up on 10/18/2024, 10/18/2024, and 10/18/2024 of:
Maplewood Gardens Assisted Living
1100 North Superior Street
Spokane, WA 99202

This document references the following SOD dated: 10/25/2024

The following sample was selected for review during the unannounced on-site visit: 3 of 188 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Amy Wright, NCI Complain 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.

J Salquist
Residential Care Services

11/05/2024
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)

11/13/2024
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain prescribed medications in a timely manner for 2 of 2 residents (Resident 1 and Resident 2). This failed practice resulted in the residents not receiving medications as prescribed and placed residents at increased risk for unmanaged symptoms, health complications, and decreased quality of life.

Findings included...

<Resident 1>

Review of an undated negotiated service agreement (NSA) for Resident 1 showed that facility staff were to order and maintain the resident's medications as per physician order.

Review of hospital discharge orders for Resident 1, dated 10/14/2024, showed that the resident was diagnosed with [redacted] ([redacted]). The discharge orders showed that Resident 1 was prescribed clopidogrel daily (a medication used to prevent stroke [damage to the brain resulting from an interruption of its blood supply], heart attack, and other heart problems). Review of the discharge orders showed that Resident 1 was to continue taking prednisone daily (a medication used to treat many diseases and conditions, especially those associated with inflammation).

Review of a medication administration record (MAR) for Resident 1, dated October of 2024, showed that the resident's clopidogrel was unavailable on 10/15/2024 and 10/16/2024. The MAR showed that the medication was not obtained for administration until 10/17/2024. Review of the MAR showed that Resident 1's prednisone was unavailable on 10/15/2024, even though it was initially ordered on 08/11/2024.

<Resident 2>

Review of an undated NSA for Resident 2 showed that facility staff were to order and maintain the resident's medications as per physician order.

Review of hospital discharge orders for Resident 2, dated 10/17/2024, showed that the resident was diagnosed as having [redacted]. The discharge orders showed that Resident 2 was to start taking a multivitamin with minerals daily on 10/18/2024. Review of the discharge orders showed that Resident 2 was prescribed Augmentin (an antibiotic medication used to treat infections) twice daily for seven days. Review of the discharge orders showed that Resident 2 was prescribed Stiolto (a medication used to relax and open the airways) daily.

Review of a MAR for Resident 2, dated October of 2024, showed that their prescribed multivitamin with minerals was never added to the MAR or administered. Review of the MAR showed that Resident 2's Augmentin was not obtained and administered until 10/19/2024, two days after it was ordered. Review of Resident 2's MAR showed that the resident's prescribed Stiolto was not obtained and administered until 10/22/2024, five days after it was ordered.

In an interview on 10/18/2024 at 10:08 AM, Staff A, Director of Nursing Services, stated that Resident 2 was prescribed an antibiotic and it took a couple of days to obtain.

In an interview on 10/25/2024 at 11:04 AM, Collateral Contact 1 (CC1), Resident Representative, stated that it often took a few days for Resident 2 to get their new prescriptions. CC1 stated that Resident 2 started on hospice on 10/18/2024, that the resident was prescribed morphine (a medication used to treat moderate to severe pain) that day, though they did not receive it until 10/21/2024 or 10/22/2024.

This is an uncorrected deficiency previously cited on 08/23/2024.

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) 12/05/2024.

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

Administrator (or Representative) — 11/13/2024 Date

Residential Care Services
Investigation Summary Report

Provider/Facility: Maplewood Gardens Assisted Living
License/Cert.#: 2470
Compliance Determination #: 45695
Investigator: Amy Wright
Investigation Date(s): 08/15/2024 through 08/23/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 141222
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):
Medications not being administered as prescribed.

Investigation Methods:

Sample:
Total residents: 184
Resident sample size: 2
Closed records sample size: 1

Observations:
Residents
Activities
Resident care equipment
Staff to resident interactions
Resident to resident interactions

Interviews:
Executive Director
Social Services Director
Alleged Victim
Resident
Resident Representative

Record Reviews:
*Disclosure of Services
*Characteristic roster
*Staff roster
*Resident face sheets
*Resident care plans
*Incident reports
*Incident investigations
*Progress notes
*Pharmacy email
*Provider email
*Provider orders
*Medication administration records
*Medication Control and Accountability Policy
*Fall Prevention and Protocol Policy

Investigation Summary:

The facility failed to obtain the Alleged Victim's prescribed medication in a timely manner. Failed practice identified and cited under WAC 388-78A-2240 Nonavailability of medications.

Conclusion / Action:

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

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Statement of Deficiencies	License # 2470	Compliance Determination # 456695
Plan of Correction	Maplewood Gardens Assisted Living	Completion Date
Page 1 of 3	Licensee: Maplewood Gardens Assisted Living Community LLC	08/23/2024

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 08/15/2024, 08/15/2024 and 08/15/2024 of:

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

This document references the following complaint number(s): 140564, 141222, 141347

The following sample was selected for review during the unannounced on-site visit: 2 of 184 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain 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 — Date: 09/04/2024

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

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 08/15/2024, 08/15/2024 and 08/15/2024 of:

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

This document references the following complaint number(s): 140564, 141222, 141347

The following sample was selected for review during the unannounced on-site visit: 2 of 184 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain 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

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) 9/9/2024 Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a prescribed medication was obtained in a timely manner for 1 of 1 resident (Resident 1). This failure resulted in sleepless nights and decreased quality of life for Resident 1 and placed facility residents at increased risk for unmanaged symptoms, health complications, and decreased quality of life.

Findings included...

Review of an undated care plan for Resident 1 showed they required assistance with medications. The care plan showed that Resident 1 used trazodone (an antidepressant medication often used as a sleep aid) to help them sleep through the night.

Review of a medication administration record (MAR) for Resident 1, dated July of 2024, showed that Resident 1 stopped receiving their trazodone on 07/26/2024. The reason was not documented on the MAR.

Review of a progress note for Resident 1, dated 07/30/2024 at 12:00 PM, showed that the resident was on alert charting for being out of trazodone. The note showed that Resident 1 was "missing [their] evening medication."

Review of a progress note for Resident 1, dated 07/30/2024 at 9:32 PM, showed that Resident 1 was not happy to be out of their trazodone.

Review of a progress note for Resident 1, dated 07/31/2024 at 1:25 PM, showed that Resident 1 was still out of their trazodone.

In an interview on 08/15/2024 at 10:45 AM, Staff A, Executive Director, stated that an issue with the pharmacy caused Resident 1 to go without their trazodone for a period of time. Staff A stated the medication was not delivered to the facility until 08/01/2024.

Administrator (or Representative) Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a prescribed medication was obtained in a timely manner for 1 of 1 resident (Resident 1). This failure resulted in sleepless nights and decreased quality of life for Resident 1 and placed facility residents at increased risk for unmanaged symptoms, health complications, and decreased quality of life.

Findings included…

Review of an undated care plan for Resident 1 showed they required assistance with medications. The care plan showed that Resident 1 used trazodone (an antidepressant medication often used as a sleep aid) to help them sleep through the night.

Review of a medication administration record (MAR) for Resident 1, dated July of 2024, showed that Resident 1 stopped receiving their trazodone on 07/26/2024. The reason was not documented on the MAR.

Review of a progress note for Resident 1, dated 07/30/2024 at 12:00 PM, showed that the resident was on alert charting for being out of trazodone. The note showed that Resident 1 was “missing [their] evening medication.”

Review of a progress note for Resident 1, dated 07/30/2024 at 9:32 PM, showed that Resident 1 was not happy to be out of their trazodone.

Review of a progress note for Resident 1, dated 07/31/2024 at 1:25 PM, showed that Resident 1 was still out of their trazodone.

In an interview on 08/15/2024 at 10:45 AM, Staff A, Executive Director, stated that an issue with the pharmacy caused Resident 1 to go without their trazodone for a period of time. Staff A stated the medication was not delivered to the facility until 08/01/2024.

In an interview on 08/21/2024 at 2:36 PM, Resident 1 stated they started taking trazodone in 2018 and they had been taking it ever since. Resident 1 stated they went without their trazodone for about a week and that they could not sleep without it. Resident 1 stated that medications were not always a problem at the facility but the problem seemed to be "getting bigger."

Review of an email, dated 07/30/2024 at 6:11 PM, showed that Staff B, Director of Nursing Services, requested that Resident 1's primary care provider write a refill order for Resident 1's trazodone (four days after Resident 1 ran out of their trazodone).

Review of an email, dated 08/15/2024 at 2:22 PM, showed that a pharmacy staff reported to Staff B that the pharmacy received the refill order for Resident 1's trazadone on 07/30/2024 and that the medication was sent to the facility on 07/31/2024.

Review of a medication administration record for Resident 1, dated August of 2024, showed that Resident 1 did not start receiving their trazodone again until 08/02/2024 (indicating they did not receive their nightly scheduled trazodone for six consecutive nights).

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) 10/04/2024.

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

Administrator (or Representative) — Date: 9/9/2024

In an interview on 08/21/2024 at 2:38 PM, Resident 1 stated they started taking trazodone in 2015 and they had been taking it ever since. Resident 1 stated they went without their trazodone for about a week and that they could not sleep without it. Resident 1 stated that medications were not always a problem at the facility but the problem seemed to be “getting bigger.”

Review of an email, dated 07/30/2024 at 6:11 PM, showed that Staff B, Director of Nursing Services, requested that Resident 1’s primary care provider write a refill order for Resident 1’s trazodone (four days after Resident 1 ran out of their trazodone).

Review of an email, dated 08/15/2024 at 2:22 PM, showed that a pharmacy staff reported to Staff B that the pharmacy received the refill order for Resident 1’s trazadone on 07/30/2024 and that the medication was sent to the facility on 07/31/2024.

Review of a medication administration record for Resident 1, dated August of 2024, showed that Resident 1 did not start receiving their trazodone again until 08/02/2024 (indicating they did not receive their nightly scheduled trazodone for six consecutive nights).

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