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

12/23/2025

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 letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 70528 (Completion Date 12/23/2025) and 66954 (Completion Date 11/07/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/23/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

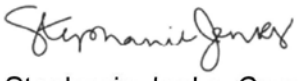
WAC 388-78A-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

The Department staff who did the On Site verification:
Sandra Fast, Community Complaint Investigator

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Maplewood Gardens Assisted Living
License/Cert.#: 2470
Compliance Determination #: 66954
Investigator: Sandra Fast
Provider Type: Assisted Living Facility
Intake ID: 196804
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 10/09/2025 through 11/07/2025
Complainant Contact Date(s): 10/08/2025, 11/20/2025

Allegation(s):

1. A resident's skin injuries were not adequately reported, monitored or documented.
2. A facility Medication Technician did not have a national fingerprint background check.

Investigation Methods:

Sample:	Total residents: 198 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified staff Identified resident Nursing staff Residents Social services
Record Reviews:	Medical records Staff training records Staff patterns Communication records

Investigation Summary:

1. The identified resident interviewed reported having sores since the end of January 2025. The resident further stated that assistance was requested of care staff, and nothing was done to assist them. The resident stated that the facility's shower aid had knowledge of the injuries. Records reviewed showed no reporting, documentation or monitoring of the identified resident's skin injuries was done. Further records reviewed no skin observations were done by the licensed nurse after knowledge of injuries. Failed facility practice was identified according to

Washington Administrative Code (WAC) 388-78a-2120(2)(a)(3)(a)(b)(4).
2. Review of a Medication Technicians personnel documents and staff schedule showed there had been no final fingerprint background check and that the MT provided services to residents two times per week. A citation was issued using WAC 388-78a-24642(1).

Conclusion / Action:

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

STATE OF WASHINGTON
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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 10/09/2025 of:

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

This document references the following complaint number(s): 196148, 196223, 196804

The following sample was selected for review during the unannounced on-site visit: 5 of 198 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sandra Fast, 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.

Residential Care Services — 11/18/2025 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) — 11/25/2025 Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

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(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff evaluated and took appropriate action for skin wounds sustained by 1 of 5 residents (Resident 4). This failure resulted in pain and ongoing skin injuries for Resident 4, and placed the resident at risk of further skin breakdown

Findings included...

Review of the facility's policy titled, "Wounds-Skin Integrity," dated 10/07/2025, showed that when staff provided Activities of Daily Living (ADL) care they were to monitor and report any indication of altered skin integrity (wounds) to the Licensed Nurse (LN) for evaluation. The policy showed that when a resident's wounds needed more than intermittent nursing care, the resident would be referred to an outside agency for wound care. The policy further indicated that the LN would complete ongoing wound

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Residential Care Services

Date

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Administrator (or Representative)

Date

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Findings included…

Review of the facility's policy titled, "Wounds-Skin Integrity," dated 10/07/2025, showed that when staff provided Activities of Daily Living (ADL) care they were to monitor and report any indication of altered skin integrity (wounds) to the Licensed Nurse (LN) for evaluation. The policy showed that when a resident's wounds needed more than intermittent nursing care, the resident would be referred to an outside agency for wound care. The policy further indicated that the LN would complete ongoing wound

assessments no less than once per week until resolved and the results would be documented in the resident's record.

Review of Resident 4's Negotiated Service Plan (NSP, the facility's titled negotiated service agreement), dated 12/26/2024 and updated 10/07/2025, showed that the resident had diagnoses of [redacted] and [redacted]. The NSP also showed that the resident required staff assistance to coordinate care with physicians and outside providers. Further review of the NSP showed that the resident received Home Health (HH) services for general care and treatment for edema related issues to their lower legs from Collateral Contact 3 (CC3), Healthcare Provider. The resident's NSP showed that staff were to provide standby assistance and cueing for Resident 4 during their showers and were to notify the LN of any red, raised, discolored or open areas, or if they were requiring additional help with any care tasks.

Review Resident 4's progress note, dated 08/18/2025, showed that Staff G, Caregiver, reported that the resident had two wounds on their buttocks that were painful.

Review of Resident 4's undated medical record showed no documentation of an LN checking the resident's buttocks wounds or any notification to CC3.

Review of an emailed communication dated 09/24/2025, from Collateral Contact 2 (CC2), Social Services Specialist, and addressed to Staff A, Executive Director, Staff B, Director of Nursing (DON), Staff C, Assistant DON, Staff D, Social Worker, Staff E, Resident Care Coordinator (RCC), and Staff F, RCC, showed that Resident 4 informed CC2 that they had wounds. Further review showed CC2 requested that a skin check be done by the facility's LN.

Review of the Resident 4's undated medical record showed no documentation of a skin check being performed by an LN for the skin injuries reported by CC2.

Review of an email titled, "New referral," and dated 09/24/25, addressed to Collateral Contact 1 (CC1), Home Health Specialist, showed Staff C, requested wound care for Resident 4's buttock wound that was described as "60 + days old." The email showed no LN skin observations.

Review of a record dated 09/30/2025 at 11:58 AM and titled, "Telephone/Care Coordination Note," by Collateral Contact 4 (CC4), Registered Nurse (RN), showed that Resident 4 had pain in their buttocks area. The record further showed that CC4 spoke with Staff F to see about getting resident wound care assistance and that Staff F stated to them that they would let the nurse know.

Review of Resident 4's undated medical record showed no documentation of any notification by Staff F, regarding the buttocks wounds, to the facility nurse.

Review of CC1's initial visit note, dated 10/01/2025, showed that Resident 4 had Deep Tissue Injury (DTI, damage to muscles, bones, or other tissues beneath the skins surface) wounds to their bilateral buttocks. The wound on the resident's left buttock was categorized as a DTI that measured 4.5 centimeters (cm) in length, width of 1.5 cm, and was distanced 0.4 cm from the wound bed to the skins surface. Further review showed that the wound contained an open area that was purple in color had an inadequate blood supply and was draining a pink watery liquid. The visit note showed that the wound on the resident's right buttock was categorized as a DTI and measured 2.5 cm in length and had a width of 1.5 cm. The wound appearance was described as purple in color.

In an interview on 10/09/2025, Resident 4 stated that they had had wounds on both buttocks since the end of January 2025. The resident further stated that the wounds were on "both cheeks [buttocks]," and were painful. The resident stated that they had trouble applying the barrier ointment they were given by CC3, in February 2025. The resident further stated that they asked the facility nursing care staff for assistance with applying the barrier cream once in February 2025 and once in March 2025. The resident stated that each time they requested assistance they were told that an order from their primary care provider was required. The resident stated that no orders for the application of the barrier cream were obtained by facility staff and that they just stopped asking after that. The resident stated that the facility bath aid had knowledge of the wounds.

Review of Resident 4's undated medical record showed no documentation of the resident's request for assistance with their barrier cream, LN notifications regarding the wounds, or observations of the wounds.

In an interview on 10/20/2025 at 2:10 PM, CC2 stated that they had notified the administrative staff about Resident 4 having buttocks wounds on 09/24/2025 and that they had asked for a skin check to be performed by the facility's LN. CC2 stated that there was no skin check or wound monitoring follow-up done by the LN.

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) 12/19/2025.

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

Administrator (or Representative) — Date: 11/25/2025

WAC 388-78A-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a national fingerprint background check was completed for 1 of 2 staff (Staff H). This failure placed residents at risk for receiving care from a potentially disqualified staff member.

Findings included...

Review of the facility's Employee Phone List, dated 09/16/2025, showed that Staff H, Medication Technician, was hired on 05/06/2025.

Review of Staff H's undated personnel files showed no documentation of a national fingerprint background check.

Review of the facility's staff schedules for August, September, and October 2025, showed that Staff H worked at the facility and provided services to resident two times per week.

In an interview on 10/09/2025, Staff A, Executive Director, stated that Staff H had an appointment for the fingerprint background check and did not attend the appointment.

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Review of the facility's staff schedules for August, September, and October 2025, showed that Staff H worked at the facility and provided services to resident two times per week.

In an interview on 10/09/2025, Staff A, Executive Director, stated that Staff H had an appointment for the fingerprint background check and did not attend the appointment.

Statement of Deficiencies	License #: 2470	Compliance Determination #: 663954
Plan of Correction	Maplewood Gardens Assisted Living	Completion Date
Page 6 of 6	Licensee: Maplewood Gardens Assisted Living Community LLC	11/07/2026

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-2120 – Monitoring Residents' Well-Being

Problems Identified and Immediate Action

Resident 4 confirmed to have been receiving Restoration Wound Care service and condition is documented as resolved as of 11/18/2025.

Identification of other concerns

Prior to wound rounds, licensed nurses review that week's clinical alerts, for compromised skin integrity, and perform skin checks.

Measures to confirm ongoing compliance

Clinical staff in-serviced on "Observing, Reporting, & Documenting" and effective communication of resident conditions.

Methods of Auditing

Residents requiring wound care reviewed at routine At Risk Meetings to ensure interventions are effectively implemented. Routine wound rounds are conducted by licensed nurses to monitor wound status, verify implementation of ordered interventions, and communicate changes in condition to the appropriate provider. Facility leadership will ensure implementation and monitoring of corrective actions no later than **12/19/25**.