STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
***8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212***

01/27/2026

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) 72000 (Completion Date 01/27/2026) and 69051 (Completion Date 12/04/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/27/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
**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

The Department staff who did the On Site verification:
Amy Wright, NCI Complain 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 #:** 69051
**Investigator:** Amy Wright
**Investigation Date(s):** 11/21/2025 through 12/04/2025
**Complainant Contact Date(s):**

**Provider Type:** Assisted Living Facility

**Intake ID:** 201591
**Region/Unit #:** RCS Region 1 / Unit B

**Allegation(s):**

1. Scabies.
2. Inadequate housekeeping.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 195<br>Resident sample size: 3<br>Closed records sample size: 2 |
| **Observations:** | Alleged Victim<br>Residents<br>Resident care equipment<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Executive Director<br>Director of Nursing Services<br>Alleged Victim<br>Resident<br>Resident Representatives |
| **Record Reviews:** | *Staff background checks<br>*Staff reference checks<br>*Medication administration records<br>*Disclosure of Services<br>*Characteristic roster<br>*Staff roster<br>*Grievance log<br>*Grievances and Complaints Policy<br>*Cleaning Resident Apartments Policy<br>*Medication Services Policy<br>*Abuse-Neglect-Exploitation Policy<br>*Resident face sheets<br>*Resident care plans<br>*Provider orders<br>*Progress notes |

*Hospital after-visit summaries
*Resident assessments
*Care conference review
*Staff in-service
*Staff training records
*Staff statement
*Staff disciplinary action
*Provider visit notes
*Staff interviews
*Resident interviews

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**Investigation Summary:**

1. Record review and interview showed there was a delay in initiating the Alleged Victim's prescribed medications ordered to treat the scabies. Failed facility practice identified and cited under WAC 388-78A-2210 Medication services (1)(b)(2)(a).
2. The Alleged Victim was interviewed, and they denied concerns about housekeeping services at the facility. The Alleged Victim's apartment was observed, and surfaces appeared clean and clutter free. Housekeeping staff were observed cleaning the Alleged Victim's apartment. Another resident was interviewed, and they reported that staff did a good job of keeping their apartment clean. No failed facility practice.

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**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 #:** 69051
**Investigator:** Amy Wright
**Provider Type:** Assisted Living Facility
**Intake ID:** 200223
**Region/Unit #:** RCS Region 1 / Unit B
**Investigation Date(s):** 11/21/2025 through 12/04/2025
**Complainant Contact Date(s):** 11/18/2025, 12/04/2025

**Allegation(s):**

1. Resident unsafe to self-administer medications.
2. Medication unavailable.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 195<br>Resident sample size: 3<br>Closed records sample size: 2 |
| **Observations:** | Residents<br>Resident care equipment<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Reporter<br>Executive Director<br>Director of Nursing Services<br>Residents<br>Alleged Victim's Representative<br>Resident Representative |
| **Record Reviews:** | *Staff background checks<br>*Staff reference checks<br>*Medication administration records<br>*Disclosure of Services<br>*Characteristic roster<br>*Staff roster<br>*Grievance log<br>*Grievances and Complaints Policy<br>*Cleaning Resident Apartments Policy<br>*Medication Services Policy<br>*Abuse-Neglect-Exploitation Policy<br>*Resident face sheets<br>*Resident care plans<br>*Provider orders<br>*Progress notes |

*Hospital after-visit summaries
*Resident assessments
*Care conference review
*Staff in-service
*Staff training records
*Staff statement
*Staff disciplinary action
*Provider visit notes
*Staff interviews
*Resident interviews

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**Investigation Summary:**

1. Interview with the Alleged Victim's Representative showed that they no longer felt the resident was safe to self-administer their medications. Record review showed that the Alleged Victim was assessed to be unsafe with self-administration of medications. Review of the Alleged Victim's care plan showed that the resident was able to safely and consistently administer their medications according to physician's order. The Alleged Victim discharged from the facility and no harm was identified as a result of the inaccurate care plan. Consultation provided under WAC 388-78A-2140 Negotiated service agreement contents (1)(a)(iii).
2. The Alleged Victim could not be interviewed as they discharged from the facility prior to the onsite visit. The Alleged Victim's Representative was interviewed, and they reported that one of the resident's medications was unavailable to the resident for a period of three to four days. Record review could not confirm that the medication was unavailable. Unable to conclusively determine that failed practice occurred.

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**Conclusion / Action:**

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

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 11/21/2025 of:

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

This document references the following complaint number(s): 201591, 201758, 200223, 202477, 202600

The following sample was selected for review during the unannounced on-site visit: 3 of 195 current residents and 2 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 — 12/12/2025 (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) — 12/19/2025 (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 implement a safe medication delivery system and to ensure medications were administered as ordered for 1 of 3 residents (Resident 1). This failed practice resulted in delayed treatment of a skin infestation, skin injury, and prolonged discomfort and pain for Resident 1.

Findings included...

Review of a negotiated service agreement intervention for Resident 1, dated 01/17/2024, showed that the facility staff were to assist with Resident 1's medications and treatments per physician's orders.

Review of a physician's order for Resident 1, dated 10/30/2025, showed that on that

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

**WAC 388-78A-2210 Medication services.**

(1) An assisted living facility providing medication service, either directly or indirectly, must:

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(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 implement a safe medication delivery system and to ensure medications were administered as ordered for 1 of 3 residents (Resident 1). This failed practice resulted in delayed treatment of a skin infestation, skin injury, and prolonged discomfort and pain for Resident 1.

Findings included…

Review of a negotiated service agreement intervention for Resident 1, dated 01/17/2024, showed that the facility staff were to assist with Resident 1’s medications and treatments per physician’s orders.

Review of a physician’s order for Resident 1, dated 10/30/2025, showed that on that

day, the resident was prescribed ivermectin (an oral medication used to treat scabies, a contagious skin infestation caused by tiny mites that burrow into the skin).

Review of a second physician's order for Resident 1, dated 10/30/2025, showed that on that day, the resident was prescribed permethrin (a topical medication used to treat scabies).

Review of a progress note for Resident 1, dated 11/01/2025 at 4:30 PM, showed that Staff A, Resident Care Coordinator, noted that the resident had a pending order for permethrin cream. The note showed that Staff A called the pharmacy and was told that the medication had already been dispensed to the facility.

In an interview on 11/21/2025 at 10:36 AM, Resident 1 stated they had scabies on their entire body though their feet itched the worst. Resident 1 stated they had pain in areas where their skin was raw and broken. Resident 1 stated they had to grit their teeth and try not to scratch. Resident 1 stated that a staff member asked them last week if they (the resident) had their permethrin cream and Resident 1 stated they did not.

Observation on 11/21/2025 at 10:40 AM, showed Resident 1 had red and inflamed feet and ankles with open areas where the resident had broken the skin while scratching.

Review of a Medication Administration Record (MAR) for Resident 1, dated November 2025, showed that the resident did not receive their first dose of ivermectin until 11/09/2025, ten days after it was ordered. Further review of the MAR showed that Resident 1 did not receive their first application of permethrin cream until 11/21/2025, 22 days after it was ordered.

This is a recurring deficiency previously cited on 06/11/2025, 02/07/2024, and 08/07/2023.

| Statement of Deficiencies | License # 2470 | Compliance Determination #690051 |
|---|---|---|
| Plan of Correction | Maplewood Gardens Assisted Living | Completion Date |
| Page 4 of 4 | Licensee: Maplewood Gardens Assisted Living Community LLC | 12/04/2025 |

**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) 1/12/2026.

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

Administrator (or Representative) — 12/19/2025 — Date

**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

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:

The Department completed a complaint investigation of your Assisted Living Facility on 12/04/2025 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 any deficiency listed on the enclosed report; and
- May inspect the facility 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 Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - 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-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:**

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

Interview with the Alleged Victim's Representative showed that they no longer felt the resident was safe to self administer their medications. Record review showed that the Alleged Victim was assessed to be unsafe with self administration of medications. Review of the Alleged Victim's care plan showed that the resident was able to safely and consistently administer their medications according to physician's order. The Alleged Victim discharged from the facility and no harm was identified as a result of the inaccurate care plan. Consultation provided under WAC 388-78A-2140 Negotiated service agreement contents (1)(a)(iii).

**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;

- Why you disagree with each deficiency; and
- Whether you want an IDR to occur in-person, by telephone or as a paper review.
- You can make an IDR request and find directions on the IDR web page at: https://www.dshs.wa.gov/altsa/idr

**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