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

02/03/2026

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) 72357 (Completion Date 02/03/2026) and 69669 (Completion Date 12/15/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/03/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

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,

JSalquist

Jessica Salquist, Regional Administrator
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Maplewood Gardens Assisted Living
License/Cert.#: 2470
Compliance Determination #: 69669
Investigator: Amy Wright
Provider Type: Assisted Living Facility
Intake ID: 203770
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 12/05/2025 through 12/15/2025
Complainant Contact Date(s): 12/03/2025, 12/16/2025

Allegation(s):

1. Improper discharge.
2. Facility disposed of former residents' belongings.

Investigation Methods:

Sample:	Total residents: 198 Resident sample size: 2 Closed records sample size: 4
Observations:	Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Reporter Executive Director Resident Care Coordinator Human Resources Director Residents Alleged Victim's Representative HCS Case Manager Director of Nursing Services
Record Reviews:	*Disclosure of Services *Characteristic roster *Staff roster *COVID-19 outbreak control checklist *IPC tool *COVID-19 line listing *Resident Discharge Policy *Resident admission agreements *Infection Control Policy *Resident discharge notices *Property removal letters *Staff in-services *Resident face sheets

*Progress notes
*Abuse-Neglect-Exploitation Policy
*Medication administration records
*Resident care plans

Investigation Summary:

1. Record review showed that a resident was discharged for known behaviors that were not addressed in the resident's negotiated service agreement. Failed practice identified and cited under WAC 388-78A-2130 Service agreement planning (3)(a)(b).
2. Record review showed that, upon admission to the facility, the Alleged Victims had agreed to remove all personal items from the facility upon discharge. The Alleged Victims could not be reached after three attempts. One of the Alleged Victim's Representatives was interviewed, though they had not been in contact with their loved one for nearly a year. One of the other Alleged Victim's Representatives could not be reached after three attempts, and the third Alleged Victim had no family or friends to contact. Record review showed that the Alleged Victims were given written notice to remove their belongings from the facility or accept delivery of their belongings to their current location, within a specified timeframe. A discharged resident's belongings were observed being stored in a facility conference room beyond their date of discharge. No failed facility practice.

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

Statement of Deficiencies	License #: 2470	Compliance Determination #69669
Plan of Correction	Maplewood Gardens Assisted Living	Completion Date
Page 1 of 4	Licensee: Maplewood Gardens Assisted Living Community LLC	12/15/2025

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 12/05/2025 of:

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

This document references the following complaint number(s): 201048, 201722, 202413, 203770

The following sample was selected for review during the unannounced on-site visit: 2 of 198 current residents and 4 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 — 12/22/2025 (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) — 12/24/2025 (Date)

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document, in the resident's negotiated service agreement, the agreed upon plan to address known behaviors affecting the resident's ability to remain safely in the facility for 1 of 3 residents (Resident 1) reviewed after discharge. This failed practice placed residents at risk for unmet care needs, decreased quality of life, safety concerns, and unwanted facility discharge related to inadequate behavioral interventions.

Findings included...

Review of an undated medical record for Resident 1 showed that the resident had a diagnosis of [redacted].

Review of a discharge notice for Resident 1, dated 06/03/2025, showed that the resident was issued a discharge notice that day because they refused to go to the dining room to eat. Review of the discharge notice showed that Resident 1 was also

being discharged because they neglected their environment.

Review of a progress note for Resident 1, dated 09/02/2025 at 6:55 PM, showed that Resident 1 had made suicidal statements to staff.

Review of a discharge notice for Resident 1, dated 09/04/2025, showed that the resident was issued their fourth discharge notice on that day. Review of the discharge notice showed that the resident was being discharged because their health and safety were at high risk due to severe self-neglect and failure to thrive. The discharge notice showed that Resident 1 refused to participate in the dining room program, they failed to meet room safety requirements and policies, and they were dropped by the in-house doctors due to refusals to follow their orders. The discharge notice showed that Resident 1 refused to follow through with the necessary doctor's appointments to ensure medication refills occurred. Review of the discharge notice showed that the facility no longer felt the resident was safe behind closed doors.

Review of a progress note for Resident 1, dated 09/05/2025 at 1:03 PM, showed that Staff A, Executive Director, and Staff B, Resident Care Coordinator, met with Resident 1 on 09/03/2025 in regard to the resident declining to go to their scheduled appointments to refill their medications. Review of the progress note showed that Resident 1 would be at risk for suffering and death if they did not attend their appointments so the facility could administer their medications. Further review of the progress note showed that Staff A stated they would need to report Resident 1's ongoing trends of self-neglect.

In an interview on 12/05/2025 at 10:41 AM, Staff A stated that Resident 1 refused to go to appointments that were required for their medication orders to be refilled. Staff A stated that the real reason for Resident 1's discharge was self-neglect.

Review of a Negotiated Service Agreement (NSA) intervention for Resident 1, dated 07/05/2024, showed that the resident ate most meals in the dining room. There was no mention in the NSA that Resident 1 had consistently refused to go to the dining room for meals.

Review of an NSA interventions for Resident 1, dated 07/05/2024, showed that the resident required staff assistance with ordering and maintaining their medications. There was no mention in the NSA that Resident 1 had refused medical appointments resulting in inadequate medication supply.

Review of an NSA intervention for Resident 1, dated 07/05/2024, showed that the resident was independent with monitoring and supervision both in and out of the community. The NSA intervention showed that the resident was able to make safe decisions. There was no mention in the NSA that Resident 1 was self-neglectful.

Review of an NSA intervention for Resident 1, dated 07/05/2024, showed that the resident required staff assistance to schedule and keep all appointments. There was no mention in the NSA that Resident 1 had a history of refusing to attend their scheduled medical appointments.

Review of an NSA intervention for Resident 1, dated 09/16/2025, showed that the resident's care plan was not updated to include interventions for their suicidal statements until that day, nine days after their discharge notice from the facility took effect, and after the resident had been discharged.

This is a recurring citation previously cited on 06/11/2025 for subsection (3)(b).

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) 1/14/2026 .
1/14/2026

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

Administrator (or Representative) Date 12/24/25