STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 73504 (Completion Date 02/25/2026) and 70226 (Completion Date 01/05/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/25/2026 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-3170-1-I, WAC 388-78A-3170-2-c

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 #: 70226
Investigator: Amy Wright
Provider Type: Assisted Living Facility
Intake ID: 203982
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 12/16/2025 through 01/05/2026
Complainant Contact Date(s): 12/26/2025

Allegation(s):
False documentation.

Investigation Methods:

Sample:
Total residents: 199
Resident sample size: 3
Closed records sample size: 1

Observations:
Alleged Victim
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Reporter
Executive Director
Director of Nursing Services
Resident Care Coordinators
Alleged Victim
Resident
Case Manager
Resident Representative

Record Reviews:
*Disclosure of Services
*Characteristic roster
*Staff roster
*Resident face sheets
*Resident care plans
*Medical records
*Emails
*Provider orders
*Skin observation sheets
*Progress notes
*Wound care notes
*Home health note
*Medication Services Policy

*Medication administration records
*Discharge notices
*Admission orders
*Nursing assessment for potential residents
*Care conference review
*Wounds-Skin Integrity Policy
*Emails

Investigation Summary:

Interview and record review showed that a managerial employee falsely documented and claimed to have provided a wound observation that did not occur. Failed practice identified and cited under WAC 388-78A-3170 Circumstances that may result in enforcement remedies (1)(l)(2)(c).

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 # 70226
Plan of Correction	Maplewood Gardens Assisted Living	Completion Date
Page 1 of 4	Licensee: Maplewood Gardens Assisted Living Community LLC	01/05/2026

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 12/16/2025 of:

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

This document references the following complaint number(s): 203647, 202893, 203982

The following sample was selected for review during the unannounced on-site visit: 3 of 199 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

Statement of Deficiencies	License #: 2470	Compliance Determination # 70226
Plan of Correction	Maplewood Gardens Assisted Living	Completion Date
Page 2 of 4	Licensee: Maplewood Gardens Assisted Living Community LLC	01/05/2026

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: 01/13/2026

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: 1/14/2026

WAC 388-78A-3170 Circumstances that may result in enforcement remedies.

(1) The department is authorized to impose enforcement remedies described in WAC 388-78A-3160 if any person described in subsection (2) of this section is found by the department to have:

(l) Knowingly or with reason to know, made false statements of material fact in the application for the license or the renewal of the license or any data attached thereto, or in any matter under investigation by the department;

(2) This section applies to any assisted living facility:

(c) Manager or managerial employee; or

This requirement was not met as evidenced by:

Based on interview and record review, a nursing staff member, who supervised the provision of care and services to the assisted living facility residents, falsely documented a wound observation and, during interview, provided the department with information that was not accurate for 1 of 1 Resident (Resident 1). This failed practice resulted in fabricated nursing documentation, which placed the resident at risk for unrecognized changes in condition, delayed interventions, and potential health complications.

Findings included...

Review of an email sent by Collateral Contact 1 (CC1), Case Manager, on 09/24/2025, showed that on that day, CC1 requested that facility staff provide Resident 1 with a skin check due to a suspected wound.

Review of a facility email sent by Staff A, Director of Nursing Services, dated 11/19/2025, showed that Staff A stated they looked at Resident 1's wound the same day CC1 requested a skin check (09/24/2025). The email showed that Staff A stated they told CC1 that Resident 1's wound was deep that same day. Staff A stated in the email that they made a skin sheet based off their observations that day.

Review of a facility document titled, "Skin Sheet," documented 11/19/2025, with an effective date of 09/24/2025, showed that Staff A, Director of Nursing Services, documented that they observed a wound which measured three centimeters by one centimeter by 0.5 centimeter on Resident 1's left buttock. The skin sheet did not indicate there were any skin impairments to Resident 1's right buttock.

Review of a wound care provider visit note for Resident 1, dated 10/01/2025, showed that the resident had two wounds which included a wound to the left buttock, which measured 4.5 centimeters by 1.5 centimeters with an open area of 0.5 centimeter by 0.5 centimeter by 0.1 centimeters, and a closed wound (an injury where the skin remains intact, but the underlying tissues are damaged) to the right buttock which measured 2.5 centimeters by 1.5 centimeters. The note showed that Resident 1's recent and remote memory were intact.

In an interview on 12/16/2025 at 12:57 PM, Resident 1 stated that Staff A never personally looked at their wounds.

In an email communication sent on 12/242025 at 4:43 PM, Staff A stated that the photograph they reviewed on 09/24/2025 was sent to them by Staff B (who had told the department that they did not photograph the wound.)

In an interview on 12/16/2025 at 12:39 PM, Staff B, Resident Care Coordinator, stated that about a week and a half before the wound care provider first saw Resident 1 (which was on 10/01/2025), CC1 asked that someone at the facility do a skin check for Resident 1. Staff B stated that the nurses were already gone for the day so Staff A had Staff B and Staff C, Resident Care Coordinator, go look at Resident 1's wound. Staff B stated they only looked at Resident 1's right buttock and that was where they saw the wound. Staff B stated that they did not take any pictures of Resident 1's wound and they did not take any measurements of the wound. CC1 stated they did not document their observation of Resident 1's wound, rather described it to Staff A in a message.

In an interview on 12/22/2025 at 8:10 AM, CC1 stated that they went to the facility and requested a skin check for Resident 1 on 09/24/2025. CC1 stated that Staff A was not at the facility at the time. CC1 stated that Staff A sent them an email on the evening of 09/24/2025, which stated that Staff A only saw one open spot on Resident 1's buttocks though it was pretty deep (indicating that Staff A observed Resident 1's buttocks that day).

Review of an email sent by Staff A to CC1 on 09/24/2025 at 5:48 PM, showed that Staff A only saw one spot on Resident 1's buttocks and that it was pretty deep.

In an interview on 12/22/2025 at 11:49 AM, Staff A stated that the first time they actually saw Resident 1's wound was on 09/29/2025. Staff A stated that the skin sheet that was dated for 09/24/2025 was misdated and should have been dated 09/29/2025. Staff A stated they could see "everything" during their observation of Resident 1's buttocks on 09/29/2025. When asked why the skin sheet with an effective date of 09/24/2025 only showed one wound on the left buttock, Staff A stated that they did see "shadowing" on the other side but they were not a doctor and they did not document it.

In an email communication sent to the department investigator on 12/24/2025 at 3:38 PM, Staff A stated they did not perform an in person assessment of Resident 1's wound on 09/24/2025 and instead reviewed a photograph of the wound provided by staff.

In an email communication sent to the department investigator on 12/24/2025 at 4:43 PM, Staff A stated that the photograph they reviewed on 09/24/2025 was sent to them by Staff B (who had told the department that they did not photograph the wound.)

In an interview on 01/05/2026 at 10:10 AM, Staff C stated they never looked at Resident 1's buttocks until after the resident was seen by the wound care provider (which was initiated on 10/01/2025). Staff C stated they never took a picture of Resident 1's wounds and they never provided a picture of Resident 1's wounds to Staff A.

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) 2/12/2026.

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

Administrator (or Representative) 1/14/2026 Date