STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

MGAL Operations LLC
Maple Glen Assisted Living
1700 N 13th Loop Rd
Shelton, WA 98584

RE: Maple Glen Assisted Living License # 2655

Dear Administrator:

This letter addresses Compliance Determination(s) 32923 (Completion Date 12/13/2023) and 29110 (Completion Date 09/11/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/13/2023 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-2600, WAC 388-78A-2600-2, WAC 388-78A-2600-2-a, WAC 388-78A-2600-2-i

The Department staff who did the on-site verification:
Pamela Horlick, NCI RN Complaint Investigator

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Maple Glen Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2655
Intake ID: 94509
Compliance Determination #: 29110
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 09/06/2023 through 09/11/2023
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Facility report of resident to resident altercation in the community.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Activities Dining Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members Management
Record Reviews:	Incident investigation Facility policies Staff training records Resident Care Plans Fit testing logs Alert charting/progress notes

Investigation Summary:
Quality of Care/Treatment: Facility investigated incident. Facility failed to follow policies and procedures to monitor resident when a resident was involved in an altercation with another resident. Failed practice identified.

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
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2655	Compliance Determination #29110
Plan of Correction	Maple Glen Assisted Living	Completion Date
Page 1 of 4	Licensee: MGAL Operations LLC	09/11/2023

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 09/08/2023 and 09/11/2023 of:

Maple Glen Assisted Living
1700 N 13th Loop Rd
Shelton, WA 98584

This document references the following complaint number(s): 93271, 94509

The following sample was selected for review during the unannounced on-site visit: 3 of 47 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Cory Cisneros
Residential Care Services

09/14/2023
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.

Jaime Cr Davis
Administrator (or Representative)

September 22, 2023
Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to follow policies and procedures on what staff must do when notified of an allegation of abuse for 2 of 2 residents (Resident 1 and Resident 2). This failure placed the residents at risk for unmet care needs.

Findings included...

Review the facility policy, titled, "Investigation Reporting", last reviewed on 08/22/2023, stated, "All incidents and accidents will be investigated to rule out abuse/neglect and to determine cause and effect. Maple Glen Assisted Living will investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting resident health or life."

Review of the facility policy, titled, "Alert Charting", last reviewed on 05/01/2023, under "Behavioral Issues", stated, Staff were required to document on the residents' behavioral changes "Once per shift, while awake with each behavior... Until resolved/returned to baseline [baseline behavior] or per Wellness Director" [instructions]. Staff are required to monitor and document behavioral changes in the resident record such as: "Resident pacing up and down hall, speaking loudly to other residents, using profanity and refusing medications." Staff were also instructed to document other specific behaviors or new behaviors the resident may be experiencing.

During an interview on 09/11/2023 at 1:26PM, Staff A, the Executive Director, was asked if staff were required to document behavioral changes when there was a resident-to-resident altercation and Staff A stated, yes, they document per policy. When asked what kind of behavioral changes for a resident would be charted, Staff A stated distress, psychological

distress or any behaviors that were out of the ordinary for the resident. When asked how long the alert charting would be done for, Staff A stated that the charting would be done until the behavior was resolved, or it would be up to the wellness director's discretion. Staff A stated that if it's up to the wellness director it would still be a minimum of 72 hours regardless.

Resident 1 (R1)

Review of R1's face sheet showed the resident was admitted to the facility on [redacted]2021.

Record review of facility incident log showed R1 was involved in a resident-to-resident altercation with Resident 2 (R2) on 08/12/2023 but was reported to facility on 08/18/2023.

Record review of incident report for R1, dated 08/18/2023, stated, "per report-[R1] reported that [R2] grabbed them and drug them into a room on Saturday [08/12/2023]."

Review of R1's progress notes, showed there no entry for the incident on 08/18/2023. There also was no entry in the progress notes for 08/19/2023, 08/20/2023 and 08/21/2023 to monitor the resident for behavioral changes. The only entry that discussed the incident in the resident record, was on 08/31/2023, which stated, the facility offered R1 escorts to and from meals, which were refused by R1.

Resident 2

Review of R2's face sheet showed that the resident was admitted to the facility on [redacted]2020.

Review of facility incident log showed R2 was involved in a resident-to-resident altercation with Resident 1 (R1) on 08/12/2023 but was reported to facility on 08/18/2023.

Record review of incident report for R2, dated 08/18/2023, showed R1 reported to Staff A that R2 grabbed them and drug them into a room on Saturday 08/12/2023.

Review of R2's progress notes showed no entry for the incident on 08/18/2023. There also was no entry in the progress notes for 08/19/2023, 08/20/2023 and 08/21/2023 to monitor the resident for behavioral changes. There was only one entry regarding the incident on 08/31/2023, per the note, Staff A discussed the incident with R2. R2 stated they have only had contact with R1 in the dining room and it was only once when their walker was in the way and R1 slammed their walker into R2's walker to get them to move it. R2 stated they have never touched or pulled them [R1] anywhere. R2 was instructed to not have any interaction with the other resident.

Statement of Deficiencies	License #: 2655	Compliance Determination # 29110
Plan of Correction	Maple Glen Assisted Living	Completion Date
Page 4 of 4	Licensee: MGAL Operations LLC	09/11/2023

During an interview on 09/06/2023 at 12:55PM, Staff B, Medication Technician, was asked what kind of charting would be done if a resident-to-resident altercation occurred and Staff B stated that there would be a chart note. Staff B was asked if both the residents involved would be put on alert to monitor and Staff B stated that they didn't think that the residents would need to be placed on alert charting unless they were physically hurt.

During an interview on 09/06/2023 at 1:22PM, R1 was asked if she felt safe in the community and R1 stated "No" she doesn't. "Not with him that close." R1 stated, "I wake up in the middle of the night thinking about it". R1 stated that they always feel "on guard". R1 stated they were scared when they see R2 close to them. R1 stated, "it makes me feel uneasy".

During an interview on 09/06/2023 at 1:37PM, Staff A was asked why alert charting was not completed for R1 and R2, and why residents weren't monitored for behavior changes, Staff A stated, "alert charting should have been done and it wasn't." When asked the reasoning it wasn't done, Staff A stated, "honestly, I forgot to put [R1] and [R2] on alert due to R1 being out of the facility."

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, Maple Glen Assisted Living is or will be in compliance with this law and / or regulation on (Date) 10/16/2023 .

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

Jaimie A Hess — Administrator (or Representative)

September 22, 2023 — Date