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) 39741 (Completion Date 04/15/2024) and 37029 (Completion Date 02/21/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/15/2024 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-2610-1

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: 119032
Compliance Determination #: 37029
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 02/20/2024 through 02/21/2024
Complainant Contact Date(s):

Allegation(s):
Infection Control: Facility report of a Covid-19 outbreak in the community.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Administrator Residents
Record Reviews:	State reporting log Facility policies Care Plans Charting Notes RPP binder

Investigation Summary:
Facility failed to ensure proper notice was in place on residents doors indicating the residents were infected with Covid-19 and proper PPE needs to be utilized prior to entry into the residents room to provide care. Failed practiced identified.

Conclusion / Action:

[X]

Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Statement of Deficiencies	License #: 2655	Compliance Determination # 37029
Plan of Correction	Maple Glen Assisted Living	Completion Date
Page 1 of 3	Licensee: MGAL Operations LLC	02/21/2024

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 02/20/2024 and 02/20/2024 of:

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

This document references the following complaint number(s): 119032, 115764

The following sample was selected for review during the unannounced on-site visit: 3 of 46 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

02/27/2024
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.

Statement of Deficiencies	License #: 2655	Compliance Determination # 37029
Plan of Correction	Maple Glen Assisted Living	Completion Date
Page 2 of 3	Licensee: MGAL Operations LLC	02/21/2024

Jamie A Adams
Administrator (or Representative)

02/08/2024
Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to post a sign on the residents door to indicate the resident was infected with COVID-19 (Corona Virus Disease 2019-an infectious disease caused by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, sore throat, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death) during a COVID-19 outbreak for 2 of 3 residents (Resident 1 and Resident 2) reviewed. This failure placed all 46 of 46 residents and 29 staff members, and visitors at risk of being infected and continue the spread of Covid-19.

Findings included...

Record review of the Washington State Department of Health document, titled, "SARS-CoV-2 Infection Prevention and Control in Healthcare Settings Toolkit", dated June 2023 (no day listed), stated, a sign with information/instructions on how to proceed entering the residents room should be placed on the door of the infected resident.

Record review of "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (Covid 19) Pandemic, dated 5/2023, stated, "The recommendations in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency." Under the section, "Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic" it stated, "Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias.) These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene.)

Review of Resident 1's (R1) face sheet showed that R1 was admitted to the facility on [redacted]/2022.

In an observation on 02/20/2024 at 10:51AM, showed a cart with PPE supplies outside R1's door. There was no sign on the door indicating the resident had an infection or what kind of precautions needed to be taken to enter the room.

Review of Resident 2's (R2) face sheet showed that R2 was admitted to the facility on [redacted]/2021.

In an observation on 02/20/2024 at 11:03 AM, showed a cart with PPE supplies outside R2's door. There was no sign on the door indicating the resident had an infection or what kind of precautions needed to be taken to enter the room.

In an interview on 02/20/2024 at 12:38 PM, Staff B, Registered Nurse, was asked what was the process when a resident was confirmed positive with Covid-19, they stated that they follow the procedure of isolation. Staff B stated staff were to wear PPE (Personnel Protective Equipment) and there needs to be isolation signs/signage on the door. They stated the sign stays on while the resident is in isolation.

In an interview on 02/20/2024 at 1:18 PM, Staff A, Executive Director, was asked what was the expectation of staff when a resident was confirmed positive with Covid-19, they stated they get the cart outside the door. Staff A stated, there was to be a sign on the residents door about what precautions the staff and visitors needed to follow.

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) 03/25/2024 .

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

Jamie A Adams — Administrator (or Representative)

2/28/2024 — Date