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

12/04/2024

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

RE: Maple Glen Assisted Living # 2655

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 51138 (Completion Date 12/04/2024) and 45264 (Completion Date 08/09/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/04/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

The Department staff who did the Off Site verification:
Celeste Vashey, ALF LTC Licensor

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: 138514
Compliance Determination #: 45264
Region/Unit #: RCS Region 3 / Unit E
Investigator: Celeste Vashey
Investigation Date(s): 08/07/2024 through 08/09/2024
Complainant Contact Date(s):

Allegation(s):
Reported concern about the dining room services and managements follow through with reported concerns.

Investigation Methods:

Sample:	Total residents: 50 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions Kitchen
Interviews:	Identified resident Identified staff Residents Kitchen staff
Record Reviews:	Grievance log State reporting log Facility policies

Investigation Summary:
Based on interview, observation, and record review failed practice was identified relating to facility staff following up with resident reported concerns.

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 # 45264
Plan of Correction	Maple Glen Assisted Living	Completion Date
Page 1 of 5	Licensee: MGAL Operations LLC	08/09/2024

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 08/07/2024 and 08/09/2024 of:

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

This document references the following complaint number(s): 138514

The following sample was selected for review during the unannounced on-site visit: 3 of 50 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Celeste Vashey, ALF LTC Licensor

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

08/13/2024
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.

Administrator (or Representative)

8/15/2024
Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to address and resolve 1 of 3 residents (Resident 1[R1]) grievances. These failures resulted in R1 having unresolved concerns and placed all 50 residents at risk for decreased quality of life.

Findings included...

RCW 70.129.060 "Grievances. A resident has the right to: (1) Voice grievances. Such grievances include those with respect to treatment that has been furnished as well as that which has not been furnished; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents."

Record review of the facility's policy, titled, "Complaint/Grievance Procedure", dated 05/01/2023, showed the facility desired to promptly and appropriately respond to all complaints and grievances from residents. The facility should have a documented system for when they received and investigated a complaint/grievance. Complaints/grievances and resolutions would be documented as part of the resident record. All team members were responsible to follow the complaint/grievance procedure.

Record review of the facility's "Resident Council" document, dated 07/05/2024, showed a typed document with handwritten notes from Resident 2 (R2) on it. Sixteen residents attended the meeting. The old business section showed in typed font "meals starting on time". R2's handwritten note next to old business read "hit or miss". The document was signed by R2 and Staff A on 07/05/2024.

Record review of the facility's, "Café Menu", undated showed yogurt was one of the options listed under the continental breakfast 8:00 AM – 11:00 AM section.

Record review of R1's untitled document (R1's negotiated service agreement), undated, showed it was signed and agreed upon on 07/30/2024. R1 moved into the facility on [redacted]/2023 and had a medical diagnosis of [redacted] ([redacted]). R1 had not experienced memory loss. R1 was orientated and could recall and retain information. Dining and meals section showed Resident 2 (R2), R1's spouse, would frequently order and pick up R1's to go meal. R2 would deliver R1's meal after they ate. Responsive behaviors section showed effective nondrug interventions used in the past included if R1 was frustrated or agitated to encourage R1 to express themselves or walk away and return when R1 calmed down.

Record review of R1's "Progress Notes", dated 06/18/2024, showed Staff B, Resident Service Director, wrote that R1 expressed concerns about the kitchen. R1 said they wanted to be taken off the food program. R1 said on 06/17/2024 they never received two of the meals they were informed they would get. R1 expressed frustration with the facility cooks. Staff B wrote Staff A, Executive Director, would be notified. Staff B informed R1 that the facility provided food as a service, and they could not deny R1 food. Staff B said R1 would need to talk to the nurse to discuss the request further. Staff B wrote that R1 said if they did not receive the food, they would rather not pay for it and cook their own food. Staff B wrote that they assured R1 that it would be discussed as soon as possible.

There were no other documented notes to review about R1's concern with the kitchen and how the facility staff followed up to address R1's concerns.

In an interview on 08/07/2024 at 12:32 PM, R1 said they had had expressed their ongoing concerns about the kitchen with Staff A. R1 said they had expressed their concerns for approximately 6 months. R1 said they wanted to eat in the dining room because it was beautiful, and they wanted to watch the wildlife from the windows. R1 said they had to eat in their room even if they did not want to. R1 said they had ongoing concerns with the cooks inside of the kitchen being able to consistently prepare food. R1 said they went down to breakfast on 08/07/2024 as they knew a new culinary director Staff C, Cook, had started and R1 wanted to have the eggs benedict that was on the menu. R1 said Staff C was not working as expected. R1 expressed concern that when Resident 3 (R3)'s eggs benedict was brought to them it was too hard for R3 to cut through. R1 said they left without eating their food in frustration that Staff C was not present and that they thought their food would be too hard to cut through when it would be delivered. R1 said they were afraid to go down into the dining room because they never knew what would be served and how long it would take them to be served. R1 said it was common for the cooks to inform residents that they did not have certain items that were supposed to be served. R1 said the facility was out of yogurt today which should be available daily. R1 said the last time they reported their concerns to Staff A was approximately 1 month ago. R1 said they got into an argument with Staff A about their dining concerns. R1 said they told Staff A they had been complaining for over 6 months. R1 said Staff A told them they could not yell at Staff A, and they needed to treat Staff A with respect. R1 said they reported their concerns to Staff D, Marketing Director, as well.

In an observation and interview on 08/07/2024 at 10:57 AM, Staff E, Activities Director,

had been in the dining room and placed silverware onto tables. Staff E said they helped serve residents meals inside of the dining room. Staff E said residents could order anything off the café menu daily. Staff E said sometimes residents expressed complaint with late dining service. Staff E said sometimes when there was turnover with facility staff and while staff learned their jobs it would delay the meal service. Staff E said R1 expressed complaint with long wait times often. Staff E said R1 directly expressed their concerns with Staff A, as R1 was noted to be very vocal. Staff E said it was R1's preference for R2 to bring R1 their meals. Staff E said since R2 brought R1 their meals then their mealtime would be delayed. Staff E said R1 surprisingly came to breakfast today.

In an interview on 08/07/2024 at 11:15 AM, Staff A, said there had been on going complaints about the kitchen. Staff A said the former culinary director stepped down from their position at the end of June 2024 and Staff C did not step into the role of culinary director until August 2024. Staff A recognized the month of July 2024 was a transition period. Staff A said there had been expressed concerns about long wait times in the kitchen. Staff A said R1 had been upset often about the meal service times. Staff A said R2 was R1's spouse and brought R1 their food after they ate in the dining room.

In an interview on 08/07/2024 at 11:32 AM, Resident 4 (R4) said sometimes mealtimes started on time and sometimes the mealtimes started late.

In an interview on 08/07/2024 at 1:10 PM, Staff F, Caregiver said facility staff tried to start mealtimes at the top of the hour of 8:00AM, 12:00PM, and 5:00 PM. Staff F said historically residents had expressed complaint about mealtimes starting on time. Staff F said if a resident had a concern, they could fill out a complaint card anonymously at the grievance box. Staff F said a resident could directly talk to Staff A, Staff D, or any other office staff member. Staff F confirmed the facility did not have yogurt to serve today. Staff F said R1 came to breakfast today and left before they were served. Staff F said normally R1 did not come to the dining room to eat their meal. Staff F said another resident at R1's table had been served their eggs benedict before R1. Staff F said they thought when R1 had to watch other people eat their food that it contributed to their aggravation. Staff F recognized that when R1 eliminated themselves from the dining area was R1's way of not upsetting themselves. Staff F explained R2 regularly delivered R1 their meals to their room to eat. Staff F said ultimately, they thought R1 wanted to eat in the dining room to socialize with other residents.

In an interview on 08/07/2024 at 1:26 PM, Staff G, Dishwasher said they had been promoted to a cook at the facility. Staff G said today was the first day they cooked the foods themselves. Staff G said mealtimes were at 8:00AM, 12:00 PM, and 5:00 PM. Staff G said they tried to serve resident meals within an hour. Staff G confirmed they were out of yogurt until the next shipment was scheduled to be delivered.

In an interview on 08/07/2024 at 1:50 PM, Staff A said R1 sometimes voiced their frustration about food and food delays often. Staff A said R1 expressed a concern today about how the service took too long. Staff A said R1 had been frustrated because R3 had a hard time cutting their English muffin on their eggs benedict. Staff A said R1 had

already been irritated and reached their boiling point. Staff A said they had not directly spoken to R1 about the concern, but they knew R1 had been upset because a caregiver informed Staff A they took too long and R1 left the dining room without being served. Staff A said when the caregiver reported R1 left the dining room it was 8:46 AM. Staff A said the last time R1 complained about dining services was on 06/17/2024 with Staff B. Staff A said they knew a follow up conversation took place and said they needed to find the nurses note. Staff A said R1 did not come off the food service program.

There were no nurses' notes provided to review that showed the facility staff followed up with R1's reported concerns about the kitchen and how the facility staff followed up to address R1's ongoing kitchen concerns.

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) ~~09/25/2024~~ 09/20/2024 JH

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

Jamie Anderson — Administrator (or Representative)

8/15/2024 — Date