



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) 37073 (Completion Date 02/21/2024) and 32910 (Completion Date 12/22/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/21/2024 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-2160

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: 103733

Compliance Determination #: 32910

Region/Unit #: RCS Region 3 / Unit E

Investigator: Pamela Horlick

Investigation Date(s): 11/21/2023 through 12/22/2023

Complainant Contact Date(s):

Allegation(s):

1. Administration/Personnel: Public complaint of resident in community being discriminated against by staff and staff not treating resident with dignity.
 2. Dietary Services: Public complaint of resident in community not receiving three meals a day.
 3. Other Services: Public complaint of resident in community not receiving housekeeping, laundry or medication services.
 4. Resident/Patient/Client Rights: Public complaint of resident in community being discriminated against by staff and staff not treating resident with dignity.
 5. Fraud/False Billing: Public complaint of resident in community not receiving services per agreement.
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Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members Social services staff Housekeeping staff Business office manager Laundry staff
Record Reviews:	State reporting log Incident investigation Facility policies Care Plan

Disclosure of Services
alert charting
Investigations
Incident Reports
Admission Agreement

Investigation Summary:

1. Administration/Personnel: Facility treating all residents with dignity and respect. No other residents identified with similar issues. Unable to substantiate claims.
 2. Dietary Services: Facility provided agreed upon three meals a day to the resident. When resident left dining area, care staff delivered meal to the room. No failed practice identified.
 3. Other Services: Facility failed to provide weekly laundering services as outlined in the negotiated service agreement. There was no system in place to ensure that residents were receiving laundry services for the resident in the community. Failed practice identified.
 4. Resident/Patient/Client Rights: Facility treating all residents with dignity and respect. No other residents identified with similar issues. Unable to substantiate claims.
 5. Fraud/False Billing: Facility billing for agreed upon services. Facility trying to work with resident. Resident refusing care and services and attempts by the facility to update resident assessment go unanswered. Not enough evidence to substantiate claims.
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Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



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

Statement of Deficiencies	License #: 2655	Compliance Determination # 32910
Plan of Correction	Maple Glen Assisted Living	Completion Date
Page 1 of 3	Licensee: MGAL Operations LLC	12/22/2023

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 11/21/2023 and 12/21/2023 of:

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

This document references the following complaint number(s): 103733, 104480, 109036

The following sample was selected for review during the unannounced on-site visit: 3 of 46 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI
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.

Jody Just

Jody Just Region 3 Field Services Administrator

Residential Care Services

12/26/2023

Date

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies	License #: 2655	Compliance Determination # 32910
Plan of Correction	Maple Glen Assisted Living	Completion Date
Page 2 of 3	Licensee: MGAL Operations LLC	12/22/2023

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)

11/4/2024

Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide the care and services as agreed upon in the negotiated service agreement for 1 of 3 residents (Resident 1 [R1]). This failure placed residents in the facility at risk of not receiving care per their agreement with the facility.

Findings included...

Review of document titled, Disclosure of Services, signed and dated [REDACTED]/2023, showed "All assisted living facilities must provide laundry services to keep your clothes clean and in good repair, and provide you with or ensure your towels, washcloths, and bed linens are laundered at least once per week.

Review of R1's face sheet showed that R1 was admitted to the facility on [REDACTED]/2023.

Review of R1's Residency Agreement, Exhibit A, titled Supplies and Services Included In Community's Assisted Living Rate, dated 03/02/2023, that weekly flat linen and personal laundry services are provided in the Assisted Living Rate.

Review of R1's Negotiated Service Agreement (NSA) last reviewed on [REDACTED]/2023, under the category titled, "Need" it stated, "the resident requires personal laundry services... Staff will provide personal laundry service for resident. Housekeeping is done once weekly per facility protocol and includes laundering of towels and bed linens... Staff to collect, wash, dry, fold and bring back/put away laundry in a reasonable time."

During an interview on 11/21/2023 at 11:32AM, R1 stated, "They used to do my laundry but since the new owners came they stopped that and I have to do my own laundry." R1 stated they have been doing their own laundry since 05/2023. During this interview R1

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stated, "See, this is what I use to do my own laundry." R1 was observed to have a bag of laundry pods in their cupboard.

On 11/21/23 at 2:29PM, Asked Staff B if there was a log to show if laundry was services were provided for residents or documentation that laundry services were refused. Staff B stated they would have to see if there is but they don't know.

On 11/21/23 at 2:45PM, Staff A was asked if there was a laundry log to keep track of laundry services. Staff A said there was. Staff A was asked to provide it for review. Review of laundry log, on 11/21/23 at 3:00PM showed there was a stack of unorganized papers with different days for different months. On the papers were handwritten room numbers under the different columns for services provided. Under the column, "laundry services", R1's room number was not written on any of them.

During an interview on 11/21/2023 at 3:15PM, Asked Staff A if laundry services are being completed for R1. Staff A stated that they are not being done because R1 refuses their laundry services. When asked Staff A if the refusals are being documented anywhere in the residents' records. Staff A stated there is no documentation that they are refusing their laundry services.

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) 01/15/2024.

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

Jain A. Jones

Administrator (or Representative)

1/4/2024

Date