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) 56909 (Completion Date 03/25/2025) and 53494 (Completion Date 01/23/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/25/2025 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-2240

The Department staff who did the on-site verification:
Phan Pham, Nurse Surveyor

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

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2655
Intake ID: 163215
Compliance Determination #: 53494
Region/Unit #: RCS Region 3 / Unit E
Investigator: Phan Pham
Investigation Date(s): 01/08/2025 through 01/23/2025
Complainant Contact Date(s):

Allegation(s):

Quality of care - Resident did not received medication as ordered.
Pharmaceutical services - Medication was not available for residents.

Investigation Methods:

Sample:	Total residents: 52 Resident sample size: 4 Closed records sample size: 0
Observations:	Named resident, residents, environment, staff interactions with residents, staff members providing care and services, and safety measures.
Interviews:	Named resident, residents and interdisciplinary team members.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:

An investigation was conducted, and allegation identified in the intake related to pharmaceutical services and care and services were reviewed. The facility failed to ensure medications were being reorder timely. Additional residents reviewed for care, services and safety had no 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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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 01/08/2025 of:

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

This document references the following complaint number(s): 163215

The following sample was selected for review during the unannounced on-site visit: 4 of 52 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Nurse Surveyor

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

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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

02/03/2025
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.

Jamie Cheney
Administrator (or Representative)

02/04/2025
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on observations, interview and record review, the assisted living facility failed to obtain prescribed medications in a timely manner for 2 of 4 sampled residents (Resident 1 and Resident 2) reviewed. This failure resulted in Resident 1 experiencing severe pain and being hospitalized, and placed both residents at risk for experiencing health complications and diminished quality of life.

Findings included..

Review of the facility's undated Medication Reordering policy, showed the Assisted Living Facility's team members were to assist the residents to make sure medications were ordered and available. Management staff members and medication technicians were responsible for complying with State regulations.

Resident 1 (R1)

Record review of R1's face sheet, dated 01/08/2025, showed R1 was admitted to the facility on [redacted]/2022 with a diagnosis including [redacted].

Record review of R1's negotiated service plan, dated 11/30/2024, showed R1 had a history of pain and required staff assistance with pain medication administration. R1

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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

02/03/2025
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)

Date

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Based on observations, interview and record review, the assisted living facility failed to obtain prescribed medications in a timely manner for 2 of 4 sampled residents (Resident 1 and Resident 2) reviewed. This failure resulted in Resident 1 experiencing severe pain and being hospitalized, and placed both residents at risk for experiencing health complications and diminished quality of life.

Findings included...

Review of the facility's undated Medication Reordering policy, showed the Assisted Living Facility's team members were to assist the residents to make sure medications were ordered and available. Management staff members and medication technicians were responsible for complying with State regulations.

Resident 1 (R1)

Record review of R1's face sheet, dated 01/08/2025, showed R1 was admitted to the facility on [redacted]/2022 with a diagnosis including [redacted].

Record review of R1's negotiated service plan, dated 11/30/2024, showed R1 had a history of pain and required staff assistance with pain medication administration. R1

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was alert, oriented and able to communicate his needs. The facility's staff were responsible for ordering and ensuring the medications were administered as prescribed.

On 01/08/2025 at 11:02 AM, R1 was observed in bed and covered with blankets. R1 stated he had been going through a Morphine (pain medication) withdrawal and 10/10 pain experienced (zero would be no pain and 10 would be the worst pain experienced) Saturday and Sunday. R1 said he had a damaged spine and had been taking Morphine for pain control the past twenty years. R1 stated staff did not reorder his Morphine and the medication was not available. R1 said he cried because of the pain and thought he was going to die. R1 stated staff gave him Tylenol. R1 stated he had to be taken to the hospital to get the pain medication on 01/06/2025.

Record review of R1's medication administration record (MAR), dated January 2025, showed on 09/27/2023 R1 had a physician order for Morphine Sulfate 15 milligrams (mg) tablet to be administered one tablet three times daily for pain. The MAR also showed staff did not administer two dosages of Morphine on 01/04/2025 and three dosages on 01/05/2025. Staff documented R1 reported pain level was 10/10 on 01/05/2025 and the medication was not available.

Record review of R1's hospital record, dated 01/06/2025 at 3:48 AM, showed R1 was seen for chronic back and leg pain. R1 was on Morphine for years and not had the prescribed medication since 01/04/2025. R1 was treated and discharged to the assisted living facility.

Resident 2 (R2)

Record review of R2's face sheet, dated 01/08/2025, showed R2 was admitted to the facility on [redacted]/2021 with a diagnosis including [redacted].

Record review of R2's negotiated service plan, dated 04/23/2024, showed R2 required staff assistance with medication supervision and administration. Staff members were responsible for ensuring R2 received her medications as ordered.

Record review of R2's MAR, dated January 2025, showed on 11/01/2023 R2 had a physician order for Primidone (seizure medication) 50 mg per tablet and to be administered three tablets nightly to treat epilepsy. R1's MAR showed staff did not administer the medication from 01/01/2025 to 01/05/2025, and was noted the medication was not available.

In an interview on 01/08/2025 at 12:40 PM, Staff B, Medication Technician, stated the medication technicians were responsible for reordering the residents' medications when there was an eight-day supply of the medication left. Staff B stated staff members had

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been trained to notify management staff and/or the pharmacy when there were issues with getting the residents' medications refilled. Staff B said R1 did not receive five dosages of Morphine from 01/04/2025 and 01/05/2025 and R1 was in a lot of pain.

In an interview on 01/08/2025 at 12:58 PM, Staff C, Resident Service Director, said R1 and R2 needed staff assistance with medication administration and re-ordering. Staff C stated the medication technicians were responsible for re-ordering the residents' medications. Staff C said the medication technicians had been trained to routinely check the residents' medications for availability during medication administration and narcotics counts to ensure re-ordering was needed. Staff C stated staff members were to notify Staff C and/or the licensed nurse when there were issues with getting the residents' medications refilled. Staff C said the medication techs had been mentored, delegated and had demonstrated that they were able to provide medication assistance to residents safely.

In an interview on 12/16/2024 at 11:47 AM, Staff E, Medication Technician, stated she had been trained to reorder residents' medications when there was a 10-day supply left. Staff E stated she would notify the health services director and/or the pharmacy when a medication was not available and/or had problems getting a medication refilled.

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) March 9, 2025 .

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

Jamie Gidney — Administrator (or Representative)

02/04/2025 — Date

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In an interview on 12/16/2024 at 11:47 AM, Staff E, Medication Technician, stated she had been trained to reorder residents' medications when there was a 10-day supply left. Staff E stated she would notify the health services director and/or the pharmacy when a medication was not available and/or had problems getting a medication refilled.

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)_____ .

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

Administrator (or Representative) Date

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