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

01/08/2025

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) 53083 (Completion Date 01/08/2025) and 49264 (Completion Date 10/28/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/08/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

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,

Jody Just Jody Just Field Services Administrator Region 3 signing for 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: 150670
Compliance Determination #: 49264
Region/Unit #: RCS Region 3 / Unit E
Investigator: Phan Pham
Investigation Date(s): 10/21/2024 through 10/28/2024
Complainant Contact Date(s):

Allegation(s):

Pharmaceutical services - The assisted living facility did not provide medication dosage when requested.
Quality of care -Prescribed medications were not given as ordered.

Investigation Methods:

Sample:	Total residents: 60 Resident sample size: 3 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, staff members, administrative and member not associated with the facility.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:

An on-site investigation was conducted, and the concerns related to pharmaceutical services, quality of care and treatments were reviewed. The resident's care plan had interventions ensure necessary care and services were being met and was being followed. Additional residents reviewed for quality of care showed the Assisted Living Facility failed to ensure staff members administered medications as ordered.

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 # 49264
Plan of Correction	Maple Glen Assisted Living	Completion Date
Page 1 of 3	Licensee: MGAL Operations LLC	10/28/2024

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 10/21/2024, 10/21/2024 and 10/21/2024 of:

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

This document references the following complaint number(s): 150670

The following sample was selected for review during the unannounced on-site visit: 3 of 60 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

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

11/07/2024
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.

Jaimie Crighton

Administrator (or Representative)

11/12/2024

Date

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility failed to ensure staff members administered medications as ordered for one of three current sampled residents (Resident 1) reviewed. This failure placed the resident at risk for experiencing difficulty breathing and health complications.

Findings included...

Review of Resident 1's face sheet, dated 10/21/2024, showed the resident admitted to the facility on [redacted]/2024 with diagnoses including [redacted] and [redacted].

Record review of Resident 1's negotiated service plan, dated [redacted]/2024, documented Resident 1 required staff assistance with her medication services.

On 10/21/2024 at 02:15 PM, Resident 1 was observed in her bed and covered with blankets. Resident 1 stated she took medications daily and staff members assisted her. Resident 1 was not able to provide additional information related to medication services.

Review of Resident 1's progress notes showed that on 09/30/2024 at 4:31 PM, staff documented the resident had fluid retention on her lower legs. On 10/02/2024 at 1:34 PM and 10/03/2024 at 2:16 PM, staff documented there was no changes in the fluid retention to Resident 1's lower extremities.

Review of Resident 1's progress notes, dated [redacted]/2024 at 2:43 PM, showed staff documented Resident 1 complained of shortness of breath. At 3:09 PM, the resident reported she was having difficulty breathing, felt like a tub in her chest and asked to go the hospital. At 11:50 PM, staff documented Resident 1 returned from the hospital appropriately 8:00 PM and there were no changes to her medications.

Review of Resident 1's hospital discharge record, dated [redacted]/2024, showed the resident returned from the hospital with diagnoses including [redacted] and [redacted]. Resident 1 had physician orders for Lasix (treat fluid retention) 20 milligrams and Potassium Chloride 10 milliequivalents (to prevent or treat low blood potassium), both medications were to be administered daily for three days.

Review of Resident 1's progress note, dated 10/14/2024 at 6:44 AM, showed staff documented Resident 1 complained of feet swelling. Staff assessed the resident and noted Resident 1's feet were visibly swollen, and her skin was tight to touch and appeared uncomfortable. On 10/16/2024 at 12:51 AM, staff documented Resident 1 received the first dose of Lasix and Potassium at dinner time on 10/15/2024.

In an interview on 10/21/2024 at 3:37 PM, Staff B, Medication Tech (MT), said the MT on shift when a resident returned from the hospital was responsible for reviewing the residents' hospital discharge papers, check for new orders, and have the new orders sent to pharmacy to have the orders filled. Staff B stated she had been trained to contact the nurse and/or management staff for clarification when an order was not clear. Staff B said a second staff member was responsible for reviewing the residents' orders to ensure new orders were addressed.

In an interview at 3:51 PM, Staff A, Director of Wellness, said the MT on shift was responsible for reviewing the residents' hospital discharge paper, checking for new orders and ensuring new orders were sent to pharmacy. Staff A stated she and/or management staff were available for assistance with physician orders as needed. Staff A said a second staff member reviewed the orders to ensure the orders were correctly transcribed into the computer system and had been addressed. Staff A stated she reviewed R1's hospital discharge paper and discovered the resident's orders had been misplaced. Staff A said she and management staff members routinely audited records to ensure orders were correctly entered and residents received medications timely.

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) ~~12/22/2024~~ (JH) 12/12/2024

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

[signature] 11/12/2024
Administrator (or Representative) Date