STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 76350 (Completion Date 04/23/2026) and 73380 (Completion Date 03/02/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/23/2026 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-2630, WAC 388-78A-2630-1, WAC 388-78A-2630-1-a

The Department staff who did the on-site verification:
Pamela Horlick, NCI RN Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley, RN

Clinton Fridley, Community Nurse 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:** 212943
**Compliance Determination #:** 73380
**Region/Unit #:** RCS Region 3 / Unit E
**Investigator:** Pamela Horlick
**Investigation Date(s):** 02/24/2026 through 03/02/2026
**Complainant Contact Date(s):**

**Allegation(s):**

1. Resident/patient/client rights: Report of staff discussing resident medical history with other residents in close proximity.
2. Resident/patient/client neglect: Report of resident being financially exploited by staff.
3. Unqualified personnel: Report of underage staff being in a car accident with resident.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 54<br>Resident sample size: 3<br>Closed records sample size: 0 |
| **Observations:** | Identified resident<br>Residents<br>Activities<br>Dining<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Identified resident<br>Nursing staff<br>Residents<br>Family members<br>Social services staff |
| **Record Reviews:** | State reporting log<br>Incident investigation<br>Facility policies<br>Witness Statements<br>Actual staff worked schedule<br>Staff List |

**Investigation Summary:**

1. Resident/patient/client rights: Based on interview and observation, residents

interviewed deny hearing staff discuss other residents medical history in public places and it was not observed. Unable to substantiate failed practice.
2. Resident/patient/client neglect: Facility failed to notify the department of the allegation of financial exploitation. Failed practice identified.
3. Unqualified personnel: Facility investigated incident followed policy and procedures. Unable to substantiate failed practice.

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**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 02/24/2026 of:

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

This document references the following complaint number(s): 210275, 212943

The following sample was selected for review during the unannounced on-site visit: 3 of 54 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

| Statement of Deficiencies | License #: 2655 | Compliance Determination # 73380 |
|---|---|---|
| Plan of Correction | Maple Glen Assisted Living | Completion Date |
| Page 2 of 4 | Licensee: MGAL Operations LLC | 03/02/2026 |

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.

Clinton Fridley RN
Residential Care Services

03/04/2026
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)

3/6/2026
Date

**WAC 388-78A-2630 Reporting abuse and neglect.**

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

**This requirement was not met as evidenced by:**

Based on interview and record review, the facility failed to ensure that staff immediately report financial exploitation to the Department's Complaint Resolution Unit for 1 of 1 residents (Residents 2 [R2]) reviewed. This failure placed all residents at risk for ongoing abuse and exploitation.

Findings included...

"RCW 74.34.035 Reports—Mandated and Permissive—Contents—Confidentiality. (1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.

Record review of the facility policy, titled, "Abuse, Neglect and Exploitation", revised 06/2019, stated, abuse is prohibited and included theft or diversion. Any staff member who had cause to believe that an incident of abuse, abandonment, neglect or financial exploitation had occurred will immediately notify state agencies as required by law.

Record review of facility records show that R2 admitted on [redacted]/2023.

Record review of Residential Care Services Online Incident Report, dated 02/17/2026, showed a report was received to the Complaint Resolution Unit (CRU) regarding R2 being financially exploited.

Record review of facility provided witness statement, dated 01/29/2026, showed R2 told Staff B, resident services director, that they feel they had been taken advantage of by Staff C, receptionist. R2 stated Staff C had been crying to them about not being able to afford Christmas gifts for their son. R2 felt obligated to "play santa" and provide presents.

Record review of facility provided witness statement, dated 02/04/2026, showed Staff D, caregiver, stated R1 talked about gifts that were sent home with Staff C.

Record review of facility provided witness statement, undated, showed Staff E, caregiver/med tech, stated R1 stated they gave Staff C Christmas gifts for their son.

Record review of facility provided witness statement, dated 01/29/2026, Staff A, Executive Director, showed R2 informed them that Staff C was stressed about not being able to provide Christmas gifts to their son. R2 stated they got excited and wanted to play secret santa and purchased a remote controlled car. R2 stated they put the remote controlled car in a laundry bag and set it by Staff C's desk and they took it home when they left for the day.

Record review of facility provided document titled, "Investigation Report and Summary-RE: Gifts and Gratuities Violation", undated, showed on 01/29/2026, R2 alleged that Staff C stole from them. Staff C was placed on administrative leave.

In an interview on 02/25/2026 at 12:55 PM, Staff A stated an allegation of staff accepting gifts from residents is financial exploitation and would fall under abuse and neglect. Staff A was asked if they should have notified the department of the allegation, they stated yes. Staff A stated they should have notified the department of the allegation but didn't think about it because they were preoccupied with another incident.

In an interview on 02/26/2026 at 2:08PM, Staff A stated they should have notified the department immediately when they were made aware of the allegation.

| Statement of Deficiencies | License #: 2655 | Compliance Determination # 73380 |
|---|---|---|
| Plan of Correction | Maple Glen Assisted Living | Completion Date |
| Page 4 of 4 | Licensee: MGAL Operations LLC | 03/02/2026 |

**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) 4/16/2026 .

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

Administrator (or Representative) Date 3/6/2026