STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

07/07/2026

One Mallards Landing, LLC
The Lodge at Mallard's Landing
7083 Wagner Way NW
Gig Harbor, WA 98335

RE: The Lodge at Mallard's Landing # 2064

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 80047 (Completion Date 07/07/2026) and 76066 (Completion Date 05/13/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/07/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2630 Reporting abuse and neglect.

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

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

The Department staff who did the On Site verification:
Michael Goulet, Complaint Investigator

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit D

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Residential Care Services

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Residential Care Services
Investigation Summary Report

Provider/Facility: The Lodge at Mallard's Landing
Provider Type: Assisted Living Facility
License/Cert.#: 2064
Intake ID: 220391
Compliance Determination #: 76066
Region/Unit #: RCS Region 3 / Unit D
Investigator: Michael Goulet
Investigation Date(s): 04/17/2026 through 05/13/2026
Complainant Contact Date(s):

Allegation(s):
1) Staff witnessed male resident touch female resident's breast in common area

Investigation Methods:

Sample:	Total residents: Resident sample size: 6 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms Staff to resident interactions
Interviews:	Residents Staff
Record Reviews:	Facility incident report

Investigation Summary:
1) Staff and resident interviews and review of facility incident report supported that the two residents were separated by staff and placed on frequent checks for safety directly following the incident. Both residents denied any sexual activity, and stated they were only holding hands in the facility cinema. Per observation, the male resident was placed on a one-on-one with staff while out of their room, and interview with facility director showed that the male resident was moved out of the facility by their family in relation to this incident, with no further issues noted. Review of facility incident report showed that facility staff did not immediately report this incident of potential sexual abuse to the department, as the incident occurred on 04/04/2026 and was not reported until 04/14/2026.
Cited per WAC 388-78A-2630 1b) Reporting Abuse and Neglect

Conclusion / Action:

- [X] Failed Provider Practice Identified / Citation(s) Written
- [ ]

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Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Residential Care Services
Investigation Summary Report

Provider/Facility: The Lodge at Mallard's Landing
License/Cert.#: 2064
Compliance Determination #: 76066
Investigator: Michael Goulet
Investigation Date(s): 04/17/2026 through 05/13/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 220400
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

1) Resident alleged that male staff had inappropriately touched the resident during toileting care

Investigation Methods:

Sample:	Total residents: Resident sample size: 6 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms Staff to resident interactions
Interviews:	Residents Staff
Record Reviews:	Facility incident report Facility investigation report Resident Service Plan detail Resident activities of daily living (ADL) log Resident progress notes

Investigation Summary:

1) Per review of the named resident's service plan, the resident was assigned to be cared for by two staff on 10/15/2025 due to similar and unfounded allegation of similar nature. Interviews with other female residents who required extensive physical assistance with personal care such as toileting and bathing did not support any inappropriate behavior on the part of the named staff members or any other facility staff. Review of the activities of daily living (ADL) log for the named resident did not support that either named staff assisted the resident with toileting on 04/06/2026. The staff in question were removed from any assistance for the named resident, and the resident was subsequently placed with female staff only for direct care. Review of facility incident report and facility investigation report showed that facility staff did not immediately report this incident of potential sexual abuse to the department, as the incident occurred on 04/06/2026 and was reported to facility

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staff by the resident on 04/07/2026, but was not reported to the department until 04/14/2026. Cited per WAC 388-78A-2630 (1b) Reporting Abuse and Neglect

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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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STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

PO Box 99250, Lakewood, WA 98496

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 04/17/2026 and 05/05/2026 of:

The Lodge at Mallard's Landing
7083 Wagner Way NW
Gig Harbor, WA 98335

This document references the following complaint number(s): 220391, 220400

The following sample was selected for review during the unannounced on-site visit: 6 of 0 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Michael Goulet, Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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

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.

Laurie Anderson
Residential Care Services

05/13/2026
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)

5.20.26
Date

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

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

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility (ALF) failed to immediately report potential sexual abuse incidents for 2 of 5 residents (Residents 1 and Resident 2). This failure placed the residents at risk of potential physical and psychosocial harm.

Findings included...

Review of a facility incident report, dated 04/14/2026, documented potential sexual abuse of Resident 1 by Resident 6. The report showed the incident allegedly occurred on 04/04/2026 and was not reported to the department by Staff B, Assistant Director of Wellness, until 04/14/2026.

Review of a facility incident report, dated 04/14/2026, documented potential sexual abuse of Resident 2 by caregivers (Staff C and Staff D). The report showed that the incident allegedly occurred on 04/06/2026 and was reported to facility staff on 04/07/2026. The allegation was not reported to the department by Staff B until 04/14/2026.

During an interview at 9:40 AM on 04/17/2026, Staff B stated that they were aware that the incidents of potential sexual abuse related to Resident 1 and Resident 2 were reported late.

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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.

Laurie Anderson
Residential Care Services

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Date

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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, The Lodge at Mallard's Landing is or will be in compliance with this law and / or regulation on (Date) 5.20.24 .

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

Administrator (or Representative)

5.20.24
Date

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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, The Lodge at Mallard's Landing 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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