STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

07/22/2026

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) 80894 (Completion Date 07/22/2026) and 78161 (Completion Date 06/04/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/22/2026 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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

The Department staff who did the On Site verification:
Paul Aube, ALF NCI

If you have any questions, please contact me at (253)254-3190.

Sincerely,
Cory Cisneros

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

Cory Cisneros, Nursing Home Allied Health Field Manager
Region 3, Unit E
Residential Care Services

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Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2655
Intake ID: 224900
Compliance Determination #: 78161
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 05/29/2026 through 06/04/2026
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Facility report of a medication error.

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 2 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Management
Record Reviews:	Incident investigation Facility policies Negotiated Service Agreements Progress Notes/Alert Charting Medication Administration Records Hospital Records

Investigation Summary:
Quality of Care/Treatment: Facility failed to ensure medications were administered per order. Failed practice identified.

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 05/29/2026 of:

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

This document references the following complaint number(s): 222767, 224900

The following sample was selected for review during the unannounced on-site visit: 2 of 57 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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

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Statement of Deficiencies	License #: 2655	Compliance Determination #: 738161
Plan of Correction	Maple Glen Assisted Living	Completion Date
Page 2 of 5	Licensee: MGAL Operations LLC	06/04/2026

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

06/05/2026
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.

ED
Administrator (or Representative)

06/29/2026
Date

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This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure residents received their medications as prescribed for 1 of 1 residents (Resident 1 (R1)). This failure resulted in R1 not receiving their narcotic pain medications as prescribed which required emergency medical treatment at a hospital due to withdrawal (a physiological response to the sudden quitting or slowing of use of a substance to which the body has grown dependent on) symptoms and placed this resident at risk for ongoing untreated pain and a decreased quality of life.

Findings included...

Review of a facility policy titled "Medication Ordering, Receiving and Storing," last reviewed on 04/2021, stated that the facility policy is to order, receive, and store medications in a timely, safe, secure, and proper manner.

WAC 388-78A-2020 defines "Medication assistance" as assistance with self-

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Residential Care Services | Date

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Administrator (or Representative) | Date

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administration of medication rendered by a nonpractitioner to a resident of an assisted living facility in accordance with chapter 246-945 WAC.

Review of R1's Face Sheet showed they admitted to the facility on [redacted]/2025.

Review of R1's Negotiated Service Agreement, signed 9/26/2024, showed that the facility was responsible for obtaining, storing, and providing medication assistance to R1.

Review of R1's Medication Administration Record (MAR) showed an order for morphine sulfate (a medication used to treat pain) 15 milligram (mg) tablets to be given three times daily. Review of R1's MAR for May 2026 showed the following:

- On 05/16/2026 two doses of 15 mg morphine sulfate were not given.
- On 05/17/2026 three doses of 15 mg morphine sulfate were not given.
- On [redacted]/2026 two doses of 15 mg morphine sulfate were not given.
- On [redacted]/2026 of 15 mg morphine sulfate were not given.

Review of R1's MAR, for May 2026, showed an order for pregabalin (a medication used to treat nerve pain) 100 mg capsule to be given two times daily. Review of R1's MAR for May 2026 showed the following:

- On 05/16/2026 one dose of 100 mg Pregabalin was not given.
- On 05/17/2026 two doses of 100 mg Pregabalin were not given.
- On [redacted]/2026 two doses of 100 mg Pregabalin were not given.
- On [redacted]/2026 two doses of 100 mg Pregabalin were not given.

Record review of R1's progress notes, dated 05/15/2025 at 12:57 PM, showed that facility staff contacted the facility pharmacy to refill R1's morphine but were informed that the order was no longer active.

Record review of R1's progress notes, dated [redacted]/2026 at 11:26 AM, showed that facility staff placed a call to R1's pain clinic to clarify why the medication order was no longer active. Facility staff were informed that R1 missed their 05/14/2026 appointment at the pain clinic. Facility staff requested that the provider re-order R1's morphine sulfate, to which the pain clinic provider declined.

Record review of R1's progress notes, dated [redacted]/2026 at 12:44 PM, showed that R1 was sleeping more than normal.

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Record review of R1's progress notes, dated [redacted]/2026 at 1:41PM, showed that R1 expressed complaints of acute pain, nausea, and vomiting, and emergency medical services (EMS) were called. At 10:42 PM, progress notes showed that R1 returned from the emergency room.

Record review of R1's progress notes, dated [redacted]2026 at 10:17 AM, showed that R1 was sent out to the emergency room for opioid (a class of powerful drugs used primarily to treat severe pain) withdrawal.

Record review of R1's progress notes, dated [redacted]2026 at 1:13PM, showed that R1 "was feeling dizzy, experiencing abdominal pain, and was vomiting and unable to hold fluids. EMS were called and resident was admitted to the hospital for several hours before discharged and brought home."

Record review of hospital notes for R1's hospital visit, on [redacted]/2026, showed the emergency room provider documented that R1 had not received their morphine for the last two to three days, which caused generalized pain, nausea, abdominal cramping, and subjective symptoms of opioid withdrawal.

Review of discharge paperwork for R1's hospital visit, on [redacted]/2026, showed that R1 was seen again in the Emergency Department for nausea, and stomach pain.

Record review of R1's facility medical records showed no documentation for review regarding the [redacted]/2026 hospital visit.

In an interview on 05/29/2026 at 9:37 AM with Staff A, Executive Director, and Staff B, Health and Wellness Director, Staff B stated that R1 had an appointment on 05/14/2026 with pain management. Staff B stated that transportation was incorrectly scheduled by the facility, which caused R1 to miss their appointment. Staff A stated it was the facility's responsibility to schedule transportation for R1's appointments. Staff B stated after the missed appointment, they began an investigation and learned that facility staff contacted R1's Primary Care Provider for a new Morphine order but stated that they were supposed to call R1's pain clinic provider for the new order. Staff B stated that this further delayed the medication being ordered. Staff B stated that after learning this, they contacted the pain clinic and learned that the provider did not want to prescribe a new order for the morphine due to the missed appointment.

In an interview with on 05/29/2026 at 9:53 AM, R1 stated, "they told me that my appointment did not get into the computer. I counted on it being set up and my transportation being provided so I didn't think about it. That morning, the car showed up, so someone knew about it. But by the time I got to the car, they had gone. So, I missed my appointment to my pain clinic. I went through withdrawals for a couple weeks. It was a week and a half actually. I ended up having to go to the hospital twice."

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Statement of Deficiencies	License #: 2655	Compliance Determination #78161
Plan of Correction	Maple Glen Assisted Living	Completion Date
Page 5 of 5	Licensee: MGAL Operations LLC	06/04/2026

R1 stated that they are starting to feel better but are still feeling effects of withdrawal symptoms at the time of the interview. R1 stated that they were upset with the facility's errors, and that this incident greatly affected them.

This is a recurring deficiency previously cited on 10/28/2024.

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) 07/19/2026.

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

D Harris ED
Administrator (or Representative)

06/29/2026
Date

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_____ _____

Administrator (or Representative) Date

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