STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC
NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
3425 Boone Road SE
Salem, OR 97317

RE: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY License # 1995

Dear Administrator:

This letter addresses Compliance Determination(s) 24551 (Completion Date 06/26/2023) and 21300 (Completion Date 03/30/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/26/2023 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-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4

The Department staff who did the on-site verification:
Michelle Mcglon, Nursing Consultant Institutional
Faith Le, NCI
Scottie Sindora, ALF Licensor
Erin Steinbrenner, Nursing Consultant Institutional

If you have any questions, please contact me at (425)670-6070.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies License #: 1995 Compliance Determination #:21300
Plan of Correction NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY Completion Date
 Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING 03/30/2023

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 follow-up on 03/17/2023, 03/17/2023, 03/27/2023, and 03/17/2023 of:
NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
1907 201ST PLACE SE
BOTHELL, WA 98012

This document references the following SOD dated: 03/30/2023

The following sample was selected for review during the unannounced on-site visit: 4 of 68 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Michelle Meglon, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

04/07/2023
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

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NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
1907 201ST PLACE SE
BOTHELL, WA 98012

This document references the following SOD dated: 03/30/2023

The following sample was selected for review during the unannounced on-site visit: 4 of 56 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Michelle Mcglon, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Residential Care Services _____ 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) 1/19/2023 Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete investigations that ruled out abuse or neglect and determined the circumstances of the incidents when 2 of 4 sampled residents (Resident 1 and Resident 2) had falls. This failure placed Resident 1 and Resident 2 at risk for abuse, neglect, and further injuries.

Findings included:

Review of the facility's undated policy titled, "Abuse, Neglect or Exploitation Policy", showed the ALF would prepare an incident report to determine the circumstances of an occurrence, and to determine appropriate measures to prevent similar future situations. The following information would be gathered: relevant information with relevant history, location and date/time of incident management, notification as appropriate (example physician, family, Complaint Resolution Unit); witness interviews, description of the incident, contributing factors, assessment of the resident, extent of injury, findings, action taken and interventions to prevent reoccurrence.

Resident 1

Review of a Resident Service Plan (RSP equivalent to NSA- Negotiated Service Agreement), dated 02/25/2023, showed the ALF admitted Resident 1 on [redacted]/2021 with multiple medical conditions to include generalized weakness. The RSP showed Resident 1's primary mode of mobility was a wheelchair and required two-person assistance with all transfers.

Review of a Resident Occurrence Report (ROR), dated 02/22/2023 at 1:30 PM, showed Resident 1's wheelchair tipped over on the ALF's bus, causing the resident to hit her head on the wall of the bus. The ROR did not include documentation that determined the

Administrator (or Representative) Date

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Review of the facility's undated policy titled, "Abuse, Neglect or Exploitation Policy", showed the ALF would prepare an incident report to determine the circumstances of an occurrence, and to determine appropriate measures to prevent similar future situations. The following information would be gathered: relevant information with relevant history, location and date/time of incident management, notification as appropriate (example physician, family, Complaint Resolution Unit), witness interviews, description of the incident, contributing factors, assessment of the resident, extent of injury, findings, action taken and interventions to prevent reoccurrence.

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Review of a Resident Occurrence Report (ROR), dated 02/22/2023 at 1:30 PM, showed Resident 1's wheelchair tipped over on the ALF's bus, causing the resident to hit her head on the wall of the bus. The ROR did not include documentation that determined the

circumstances that caused Resident 1's wheelchair to tip over, how to prevent reoccurrence, if Resident 1's family representative was notified, or rule out abuse and neglect.

Resident 2

Review of a RSP, dated 8/17/2022, showed the ALF admitted Resident 2 on [redacted]/2020 with multiple medical conditions to include Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions) and dementia (a group of thinking and social symptoms that interferes with daily functioning).

Review of a ROR, dated 03/02/2023 at 10:00 PM, showed Resident 2 reported to the ALF staff she fell in her apartment. The ROR did not include documentation that determined the circumstances that caused Resident 2's fall, how to prevent reoccurrence, if Resident 2's family representative was notified, or rule out abuse and neglect.

In an interview, on 03/30/2023 at 3:13 PM, Staff A (Assisted Living Director) stated that he was new to his position and was learning how to complete RORs. Staff A confirmed the ROR's were incomplete.

This is an uncorrected deficiency previously cited on 01/30/2023.

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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) May 14, 2023.

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

Administrator (or Representative) 4/14/2023 Date

circumstances that caused Resident 1's wheelchair to tip over, how to prevent reoccurrence, if Resident 1's family representative was notified, or rule out abuse and neglect.

Resident 2

Review of a RSP, dated 8/17/2022, showed the ALF admitted Resident 2 on [redacted]/2020 with multiple medical conditions to include Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions) and dementia (a group of thinking and social symptoms that interferes with daily functioning).

Review of a ROR, dated 03/02/2023 at 10:00 PM, showed Resident 2 reported to the ALF staff she fell in her apartment. The ROR did not include documentation that determined the circumstances that caused Resident 2's fall, how to prevent reoccurrence, if Resident 2's family representative was notified, or rule out abuse and neglect.

In an interview, on 03/30/2023 at 3:13 PM, Staff A (Assisted Living Director) stated that he was new to his position and was learning how to complete RORs. Staff A confirmed the ROR's were incomplete.

This is an uncorrected deficiency previously cited on 01/30/2023.

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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY 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

Residential Care Services
Investigation Summary Report

Provider/Facility: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1995
Compliance Determination #: 17899
Investigator: Michelle Mcglon
Investigation Date(s): 12/28/2022 through 01/30/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 63654
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):

1. The Assisted Living Facility (ALF) was short staff, resulting in resident care needs not being met.
2. The Named Resident (NR) was left on the toilet for over an hour.
3. The NR had multiple falls due to the ALF being short staffed.
4. The NR had a fall with injury, and called 911 because the ALF staff had not responded to the emergency call light.

Investigation Methods:

Sample:	Total residents: 79 Resident sample size: 2 Closed records sample size:
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions
Interviews:	Identified resident Nursing staff Family members
Record Reviews:	Incident investigation Staff Schedule

Investigation Summary:

1. Observation, interview and record review showed the ALF had qualified staff on each shift.
2. In an interview, the NR stated that staff had been delayed, when helping other residents. The NR stated that the ALF staff answer the call lights, when they were available. Review of the ALF's average call light response showed the NR's call lights were answered within a 5 minute on average.
3. Review of ALF incident reports/investigation showed that the NR had falls, that were not related to staffing shortages.

4. The NR stated that they had a fall, pressed their emergency pendant, and the ALF staff called 911. The emergency responders accessed the NR, and it was determined the NR did not require transportation to the hospital. Based on interview and Record review the ALF failed to complete an investigation to rule out abuse and neglect or determine the cause of the fall. Therefore, interventions were not put in place to prevent reoccurrence.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies License # 1995 Compliance Determination # 17899
Plan of Correction NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY Completion Date
Page 1 of 4 Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING 01/30/2023

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 12/28/2022, 12/28/2022 and 12/28/2022 of:

NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
1907 201ST PLACE SE
BOTHELL, WA 98012

This document references the following complaint number(s): 63654, 63002

The following sample was selected for review during the unannounced on-site visit: 2 of 79 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Michelle Mcglon, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98096

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.

Jamie Singer
Residential Care Services

1/31/2023
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) 2/7/2023 Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

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(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record the Assisted Living Facility (ALF) failed to complete investigations that ruled out abuse or neglect and determined the circumstances when 2 of 2 sampled residents (Resident 1 and 2) had unwitnessed falls. This failure placed Residents 1 and 2 at risk for abuse, neglect, and further injuries.

Findings included....

Review of the facility's undated policy title, "Abuse, Neglect or Exploitation Policy", showed the ALF would prepare an incident report to determine the circumstances of the event and to determine appropriate measures to prevent similar future situations. The following information would be gathered, relevant information with relevant history, location and date/time of incident management, notification as appropriate (example physician, family, Complaint Resolution Unit), witness interviews, description of the incident, contributing factors, assessment of the resident, extent of injury, findings, action taken and interventions to prevent reoccurrence.

Resident 1

Review of a Quarterly Licensed Nurse Evaluation Summary, dated 08/30/2022, showed the ALF admitted Resident 1 on [redacted]/2018 with multiple medical conditions including Fibromyalgia (a disorder causing widespread muscle pain and tenderness, fatigue, altered sleep, memory, and mood.)

Review of a Charting Notes, dated 12/22/2022 at 8:40 PM, showed Resident 1 was on alert charting for a fall with injury. The Charting Notes showed Resident 1 had sustained a head laceration (cut). Resident 1 had been assessed by the emergency medical professionals but

was not transported to the hospital.

In an interview, on 12/28/2022 at 2:00PM, Staff B (Assisted Living Director) stated that she did not have an investigation or incident report completed for Resident 1 from the fall documented on 12/22/2022

In an interview, on 12/28/2022 at 2:08 pm, Resident 1 stated the fall on 12/22/2022 resulted in a head laceration and her head remained tender to touch. Resident 1 stated that the ALF management staff had not spoken to her about the fall.

In an interview, on 12/28/2022 at 2:37 PM, Staff A (Executive Director) stated that Staff B had the investigation/incident report and would provide the documentation to the Department Staff.

In an interview, on 12/28/2022 at 3:07 PM, Staff B stated again that she did not have an investigation/incident report for Resident 1.
The Department Representative requested investigations/incident reports for Resident 1 on four occasions from Staff A during the onsite visit. The requested investigation/incident report was not received by the Department.

Resident 2

Review of a Quarterly Licensed Nurse Evaluation Summary, dated 05/11/2022, showed the ALF admitted Resident 2 on [redacted]/2021 with multiple medical conditions to include dementia (a group of thinking and social symptoms that interferes with daily functioning.)

Review of a handwritten Resident Occurrence Report (equivalent to an investigation), dated 10/10/2022 at 5:50 AM, showed Resident 2 had a fall without injury. The document did not show notifications were made by the ALF staff to Resident 2's physician, family, or ALF administrative staff. The document did not show the investigation was completed to determine cause or prevent reoccurrence.

Review of a Resident Occurrence Report, dated 11/29/2022, showed Resident 2 experienced another fall. The document did not show the investigation was completed to determine cause or prevent reoccurrence.

In an interview, on 12/28/2022 at 1:43 PM, Staff A was informed that Resident 2 's Resident Occurrence Reports had not been completed to rule out abuse and neglect or to determine the cause of the fall. Staff A stated that the ALF staff would need to make late entries to complete the investigations.

This is a repeat deficiency previously cited on 08/17/2021.

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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 2/10/2023 .

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

Administrator (or Representative) 2/7/2023 Date