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) 28100 (Completion Date 08/18/2023) and 25825 (Completion Date 06/26/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/18/2023 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-2210-1, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2

The Department staff who did the on-site verification:
Michelle Mcglon, 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 # 25825
Plan of CorrectionNORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY Completion Date
Page 1 of 3 Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING 06/26/2023

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 04/25/2023 and 04/27/2023 of:
NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
1907 201ST PLACE SE
BOTHELL, WA 98012

This document references the following SOD dated: 06/26/2023

The following sample was selected for review during the unannounced on-site visit: 3 of 53 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.

Jamie Singer
Residential Care Services

06/28/2023
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) July 8, 2023 Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 2 residents (Resident 1) received their medications as prescribed by a physician. This failure resulted in Resident 1 missing scheduled medications and placed them at risk for health complications.

Findings included...

Record review showed the ALF admitted Resident 1 on medication services on [redacted]/2023 with a diagnosis of [redacted] and [redacted]. Review of a Resident Service Plan, dated [redacted]/2023, showed Resident 1 was to receive medication management assistance.

Record review of the April 2023 Medication Administration Record (MAR) showed Resident 1 had a physician's order for Lamotrigine 100 MG (milligrams) by mouth every evening for seizures. Record review of the MAR showed no initials, indicating Lamotrigine was given, at 8 PM on 04/01/2023 and 04/02/2023.

Record review of the April 2023 MAR showed Resident 1 had a physician's order for Multaq 200 MG give half tablet by mouth in the morning and at bedtime for atrial fibrillation (an irregular heartbeat). Record review of the MAR showed no initials, indicating Multaq was given, at 8 AM and 8 PM on 04/02/2023 and 8 AM on 04/03/2023.

In an interview, on 05/08/2023 at 10:39 AM, Resident 1 stated that she knew she did not receive all her medications as prescribed on 04/01/2023 and 04/02/2023.

In an interview, on 04/25/2023 at 1:25 PM, Staff A (Registered Nurse) confirmed that the Lamotrigine and Multaq were not given as prescribed to Resident 1 on 04/01/2023 and

04/02/2023.

This is an uncorrected deficiency previously cited on 02/28/2023.

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) JULY 31, 2023 .

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

Administrator (or Representative) July 8, 2023 Date

Residential Care Services
Investigation Summary Report

Provider/Facility: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1995
Compliance Determination #: 21648
Investigator: Jamie Singer
Investigation Date(s): 03/27/2023 through 03/29/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 72128
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):

1. The Assisted Living Facility (ALF) assisted with medications for 6 days, that the Named Resident (NR) was supposed to self-administer.
2. The ALF staff failed to remove existing medications from the NR's possession prior to managing medications.
3. The NR missed medications due to ALF staff being unprepared for a group outing.
4. The NR did not receive showers as agreed upon in the Resident Service Plan (RSP).
5. The ALF Medication Technicians did not make notes of resident concerns in the medical record.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 1 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Executive Director Family members
Record Reviews:	Resident records

Investigation Summary:

1. Observation, interview, and record review showed the ALF failed to provide clear instructions on the NR's Medication Administration Record (MAR), which resulted in the NR receiving a double dose of insulin.
2. Record review showed the NR was assessed as being able to self-administer his bedtime insulin. Observation and interview showed the NR had their own supply of insulin and were self-administering. Record review showed the ALF staff were

delivering insulin to the NR to inject at bedtime causing a double dose of insulin.
3. In an interview, the NR's family member stated that the resident received a medication prior to leaving for an outing. The Executive Director (ED) stated that a list was provided to the bus driver of all residents that required medications, before leaving for an outing.
4. Record review of the NR's RSP showed the resident was independent with showers. The ED stated she had a meeting scheduled with the NR and family to resolve any confusion with care.
5. Interview and record review showed the staff wrote notes in the NR's chart notes as needed.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1995
Compliance Determination #: 21648
Investigator: Jamie Singer
Investigation Date(s): 03/27/2023 through 03/29/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 74774
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):
1. The Assisted Living Facility had a combination lock on the inside gate of the Memory Care Unit's (MCU) courtyard.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 1 Closed records sample size: 0
Observations:	Residents Resident to resident interactions Staff to resident interactions Combination lock on the inside gate of MCU no combination code near lock
Interviews:	Nursing staff Assistant Executive Director Memory Care Director
Record Reviews:	Characteristic Roster

Investigation Summary:
1. Observation showed the ALF failed to use the appropriate and safe lock for the inside gate in the courtyard on the MCU. The ALF failed to post a combination code near the gate's exit. The ALF staff reported they did not know the combination code to the lock or where to locate the combination code. In interview, a Fire Marshal stated this form of lock was not acceptable due to risk of egress during a fire. This failure placed residents, staff, and visitors at risk for harm in the care of an emergency.

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 #: 1995 Compliance Determination # 21648
Plan of CorrectionNORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY Completion Date
Page 1 of 5 Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING 03/29/2023

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 03/27/2023 and 03/27/2023 of:

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

This document references the following complaint number(s): 72128, 74774

The following sample was selected for review during the unannounced on-site visit: 1 of 56 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 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

3/30/2023
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) 4/5/23 Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 (ALF) failed to ensure instructions for a self-administered medication was accurate in the Medication Administration Record for 1 of 1 sampled resident (Resident 1). The failure resulted in Resident 1 receiving a double dose of insulin for 6 days.

Findings included...

NOTE: According to lantus.com Lantus is a long-acting man-made insulin used to control high blood glucose in adults and children with diabetes mellitus. The most common side effect of Lantus is hypoglycemia (low blood sugar), which may be serious and life threatening.

Record review of a Resident Service Plan (RSP-equivalent to Negotiated Service Plan), dated 12/29/2022, showed the ALF admitted Resident 1 on [redacted]2022 with a diagnosis of [redacted]. The RSP showed Resident 1 had demonstrated adequate ability to accurately draw and self-administer Lantus from an insulin vial independently.

In observation and interview, on 03/27/2023 at 2:553 PM, Collateral Contact 1 (CC1) a family member, stated that Resident 1 had always self-administered the Lantus. Observation showed a vial of Lantus and insulin syringes in Resident 1's apartment. CC1 stated that the care staff had never been involved in the administration of Resident 1's Lantus however recently care staff had brought an insulin pen to Resident 1 to administer before bedtime.

In an interview, on 03/27/2023 at 12:15 PM, Collateral Contact 2 (CC2) a family member, stated that he had observed the ALF staff brining an insulin pen to Resident 1 before bedtime when he was visiting a week prior.

Record review of Resident 1's February 2023 MAR showed two orders for Lantus insulin, inject 7 units under the skin daily at bedtime for self-administration. One of the orders did not have special instructions and was marked as discontinued. The second order included special instructions that directed staff to, "deliver insulin pen" to Resident 1. Due to the Lantus order being a self-administered medication there should have been no initials indicating a staff member had administered insulin to Resident 1, however the MAR showed from 02/13/2023 through 02/19/2023 ALF staff had initialed indicating they administered Lantus insulin to Resident 1.

Record review of a Resident Occurrence Report, dated 02/20/2023, showed the facility documented Resident 1 had reported the ALF staff brought in an unrecognized insulin pen to him to administer at bedtime. During that time frame Resident 1 reported having low blood sugar levels.

In an interview, on 03/29/2023 at 2:31 PM, Staff A (Executive Director) stated that the February 2023 MAR instructions to bring insulin when Resident 1 was already self-administering his own supply was confusing and unsafe.

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) 4/1/23 .

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

Administrator (or Representative) 4/5/23 Date

WAC 388-78A-2380 Freedom of movement. An assisted living facility must ensure all of the following conditions are present before moving residents into units or buildings with exits that may restrict a resident's egress:

(3) The assisted living facility must have a system in place to inform and permit visitors, staff persons and appropriate residents how they may exit without sounding the alarm.

(7) Buildings from which egress is restricted have:

(a) A system in place to inform and permit visitors, staff persons, and appropriate residents freedom of movement; and

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to have the proper lock on an outdoor gate in the memory care unit (MCU). This failure placed12 of 12 sampled residents, ALF staff, and visitor's safety at risk during an emergency.

Findings included...

Observation, on 03/17/2023 12:58 PM and 03/27/2023 2:20 PM, showed a combination lock (a lock that is opened by rotating a dial in specific directions, marked with numbers through a sequence) on the inside gate in the courtyard on the MCU.

In an interview, on 03/17/2023 at 1:09 PM, Staff D (Medication Technician) stated that she did not know the combination code to the lock on gate in the courtyard on the MCU.

In an observation and interview, on 03/17/2023 at 1:12 PM, Staff E (Medication Technician) stated that she knew where to find the combination code to the lock on gate in the courtyard on the MCU. Staff E opened the top drawer to the medication cart and showed a group of six handwritten numbers written on the inside drawer of the cart. The numbers did not provide instructions on what they were used for.

In an interview, on 03/17/2023 at 1:15 PM, Staff F (Memory Care Director) stated that she did not know the combination code to the lock on the gate in the courtyard on the MCU. Staff F stated she was sure Staff E knew the code.

In an interview, on 03/17/2023 at 1:30 PM, Staff C (Registered Nurse) stated that she did not know the combination code to the lock on the gate in the courtyard. Staff C stated that she was not sure what would happen in case of a fire.

In an interview, on 03/20/2023 at 11:27 AM, Collateral Contact 3 (CC3) a Deputy Chief Fire Marshall stated that a combination lock was not appropriate or safe for use due to the specific attention to detail with combination code. CC3 stated that this type of lock may require multiple attempts before the lock could be opened.

In an interview, on 03/21/2023 at 4:07 PM, Staff B (Assistant Executive Director) stated that she did not know the combination code to lock on the gate in the courtyard on the MCU. Staff B stated that she had no plans of being in the building alone and assumed someone in the building would know the combination code to the lock in case of an emergency.

Plan/Attestation Statement

Statement of Deficiencies	License #: 1995	Compliance Determination # 21648
Plan of CorrectionNORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY		Completion Date
Page 5 of 5	Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING	03/29/2023

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) 4/11/2023 .

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

Administrator (or Representative) 4/5/23 Date