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) 30880 (Completion Date 10/11/2023) and 27471 (Completion Date 08/22/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/11/2023 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-2240

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

Residential Care Services
Investigation Summary Report

Provider/Facility: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1995
Compliance Determination #: 27471
Investigator: Michelle Mcglon
Investigation Date(s): 08/01/2023 through 08/22/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 89203
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):

1. The Named Resident (NR) missed a prescribed medications for 3 days due to non availability at the Assisted Living Facility (ALF).
2. The ALF staff were not following a physician order to weigh the NR twice per week.
3. The ALF staff were notifying Named Resident 2 (NR2) when they were close to running out of medications.
4. NR2 had inconsistencies on their care plan

Investigation Methods:

Sample:	Total residents: 58 Resident sample size: 2 Closed records sample size:
Observations:	Identified resident Residents Staff to resident interactions
Interviews:	Identified resident Nursing staff Family members
Record Reviews:	Resident Records Incident Reports

Investigation Summary:

1. Based on interview and record review the ALF failed to notify the pharmacy and physician prior to the NR running out of a prescribed medication to manage chest pain. In an interview, the Assisted Living Director stated that the ALF staff did not notify the physician until after the NR had missed five doses of the medication. The ALF nurse stated that the NR should not have ran out of the medication.
2. Record review of the Medication Administration Record (MAR) showed the AFL staff had documented the weights and when the NR refused weights. The ALF staff did not notify the physician when the NR had a weight gain over the physician ordered parameters. Citation for Coordination of Care issued on 06/26/2023 and uncorrected during a follow-up visit 08/14/2023.

3. The ALF nurse stated that NR2 and their family representative were previously reordering injectable medications. The ALF nurse stated that the staff were now in charge of ordering all medications for NR2.
4. In an interview, NR2's family member stated that they were working with the ALF on resolving the inconsistencies. The ALF nurse stated they were continuing to work with the resident and family on the care plan.

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 # 27471
Plan of CorrectionNORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY Completion Date
Page 1 of 3 Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING 08/22/2023

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 08/01/2023, 08/01/2023 and 08/14/2023 of:

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

This document references the following complaint number(s): 89203

The following sample was selected for review during the unannounced on-site visit: 2 of 58 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

8/23/2023
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) September 1st, 2023 Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

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 sampled residents (Resident 1) had physician's ordered medication available in the facility. This failure placed Resident 1 at risk for health complications and pain.

Findings included...

Record review of an undated ALF policy, "Medication Systems", showed the ALF would establish a supply/order system to have resident medications available when needed, and document and notify when medications was unavailable.

Record review of a Resident Service Plan (RSP-equivalent to a Negotiated Service Agreement), dated 04/01/2023, showed the ALF admitted Resident 1 on [redacted]/2022 with multiple diagnoses including [redacted] and [redacted]. Record review showed the ALF managed Resident 1's medications and assisted with medication administration.

Record review of a Medication Administration Record (MAR), dated July 2023, showed a physician's order for ranolazine 500 mg (milligrams), take one tablet by mouth twice daily for chest pain. The July MAR showed Resident 1's ranolazine was not given on 07/01/2023 at 8 AM and 8 PM, 07/02/2023 at 8 AM and 8 PM, and 07/03/2023 at 8 AM. The MAR showed documentation that these doses were not given because the ALF was out of the medication, and the medication had not arrived from the pharmacy.

Record review of a Chart Note, dated 07/03/2023, showed the ALF staff notified Resident 1's physician (Cardiologist) and family, after the resident had already missed four doses of ranolazine. The Chart note showed Resident 1's family called the physician's (Cardiologist) office, and a new prescription was sent to a local pharmacy. The ranolazine was picked up by the family and delivered the ALF.

In an interview, on 08/01/2023 at 12:30 PM, Staff A (Registered Nurse) stated that

Resident 1 should not have missed medications.

This citation was previously cited on 02/26/2021.

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) 9/30/2023 .

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

Administrator (or Representative) Date: Sept 1st, 2023