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) 43167 (Completion Date 07/17/2024) and 38067 (Completion Date 04/30/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/17/2024 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-2100-2-a, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-b-ii, 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

If you have any questions, please contact me at (253)312-1446.

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 #: 38067
Investigator: Michelle Mcglon
Investigation Date(s): 03/11/2024 through 04/30/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 122123
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):

1. The Assisted Living Facility (ALF) staff dropped the Named Resident (NR), resulting multiple injuries.
2. The NR has a pressure ulcer to coccyx.
3. The NR was not consistently receiving nectar thick liquids and pureed food. Family provides thicken liquids.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Resident care equipment Resident rooms
Interviews:	Family members Nursing staff Executive Director
Record Reviews:	State reporting log Incident investigation Resident Records

Investigation Summary:

1. Interview and record review showed the ALF staff did not drop the NR. The NR had a fall, resulting in injuries. The ALF completed an investigation. Interventions were put in to place to prevent reoccurrence. The ALF failed to complete an updated assessment to include current care needs and defined roles for the staff and hospice. See Statement of Deficiencies dated 04/24/2024.
2. Interview and record review showed the ALF had orders to reposition and offered to turn and reposition as needed which was often refused by family representative. Third party provider was monitoring and treating wounds. No failed practice identified
3. In an interview, the ALF staff reported the NR received the pureed diet as prescribed,

the ALF does not provide thickened liquids and requested the family provide. The Executive Director stated that the NR's family was to provide the nectar thick liquids. Record review showed the ALF failed to complete an updated assessment to include a change in diet. See Statement of Deficiencies dated 04/24/2024.

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 #: 38067
Investigator: Michelle Mcglon
Investigation Date(s): 03/11/2024 through 04/30/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 121833
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):
1.The Named Resident (NR) was disruptive and breaking furniture.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions Resident rooms
Interviews:	Identified resident Residents Nursing staff Family members
Record Reviews:	State reporting log Resident Records Incident investigation

Investigation Summary:
1. In an interview, the ALF staff reported the NR had thrown furniture breaking a window. Record review showed the ALF had not completed an investigation to determine the circumstances surrounding the NR's disruptive behavior, or put interventions in place to protect the residents from the NR. Failed practice identified WAC 388-78A-2371(1)(2)(3)(4). See Statement of Deficiencies dated 04/24/2024.

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 #: 38067
Investigator: Michelle Mcglon
Investigation Date(s): 03/11/2024 through 04/30/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 120068
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):
1.The Named Resident (NR) eloped from the Memory Care Unit (MCU).

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions Resident rooms
Interviews:	Nursing staff Identified resident
Record Reviews:	State reporting log Incident investigation Resident Records

Investigation Summary:
1. Observation showed egress doors in the Memory Care Unit were alarmed and operational. In an interview, the Memory Care Director (MCD) stated that the NR had eloped from the MCU through one of the alarmed doors. Observation showed the NR pushing open the doors and setting off the alarms on a frequent basis. Record review showed the MCD failed to complete an investigation to determine the circumstances surrounding the elopement and implement interventions to re-direct and monitor the NR. Failed practice identified WAC 388-78A-2371(1)(2)(3)(4). See Statement of Deficiencies dated 04/24/2024.

Conclusion / Action:

☒ 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 #: 38067
Investigator: Michelle Mcglon
Investigation Date(s): 03/11/2024 through 04/30/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 120746
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):

1.The Assisted Living Facility (ALF) staff dropped the Named Resident (NR), resulting in multiple injuries.
2. The ALF staff refused to help transfer the NR, resulting in a fall and injuries.
3. The NR was lying on the floor bleeding, and the NR's family had to call 911.
4. Someone was coming into the NR's room.
5. The ALF staff were not checking on the NR.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Resident care equipment Resident rooms Resident rooms Food preparation
Interviews:	Family members Nursing staff
Record Reviews:	State reporting log Incident investigation Resident Records

Investigation Summary:

1. Interview and record review showed the ALF staff did not drop the NR. The NR had a fall, resulting in injuries while receiving care from an outside provider. The ALF completed an investigation and ruled out abuse and neglect. Interventions were put in to place to prevent reoccurrence. Sample resident representatives reported no concerns with care. The ALF failed to complete an updated assessment to include the NR's current care needs. See Statement of Deficiencies dated 04/24/2024.
2. In an interview, the ALF staff denied refusing to assist with transferring the NR, the

staff stated the third party provider did not notify the staff assistance was needed. In interview, sampled residents denied staff ever refusing to assist them. The ALF failed to complete an updated assessment and Negotiated Care Agreement to include the NR's transfer assistance needs. See Statement of Deficiencies dated 04/24/2024.
3. In an interview, the NR's family representative stated that they were in the apartment at the time of incident and called 911. In an interview, the ALF staff reported 911 had been called prior to the staff responding to the NR's apartment. Record review showed the facility had appropriate policies in place for responding to medical emergencies. No failed practice identified.
4. Observation showed the NR was living in the Memory Care Unit along with ambulatory residents with cognitive deficits. Interview and record review showed some resident would wander and could enter the NR's room. Record review showed the staff monitored, did safety checks and re-directed resident appropriate to the setting. No failed practice identified.
5. Interview and record review showed that the NR's family representative was often with the resident and had declined care when staff would check on the NR. In interview, the ALF staff had reported checking on the resident frequently. Observation showed the NR was clean, well kept and comfortable in her apartment. No failed practice identified.

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 #: 38067
Investigator: Michelle Mcglon
Investigation Date(s): 03/11/2024 through 04/30/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 119695
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):
1. The Named Resident (NR) was allegedly pushed by Named Resident 2 (NR2), resulting in a head injury and fracture.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Identified resident Residents Family members
Record Reviews:	State reporting log Incident investigation Resident Records

Investigation Summary:
1. In an interview, the NR and NR 2 did not recall the incident. The Assisted Living Facility (ALF) staff called 911 and the NR was transported to the emergency department. Record review showed the MCD failed to investigate to determine the circumstances surrounding the altercation and implement interventions to protect the residents from NR2. Failed practice identified WAC 388-78A-2371(1)(2)(3)(4). See Statement of Deficiencies dated 04/24/2024.

Conclusion / Action:

☒ 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 #: 38067
Investigator: Michelle Mcglon
Investigation Date(s): 03/11/2024 through 04/30/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 122828
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):

1. The Named Staff 1 (NS1) aggressively grabbed Named Resident 1(NR1)' s arm and made him sit down, resulting in redness to his left arm.
2. Named Resident 2 (NR2) had a bad bruise to their left arm.
3. Named Staff 1 (NS1) and Named Staff 2 (NS2) were verbally abusing Named Resident 3 (NR3) and kicking their wheelchair.
4. The Memory Care resident were left wet and soiled, no care staff were checking on them.
5. There were staff names on the schedule that do not exist.
6. The Memory Care Director was covering up incidents.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 4 Closed records sample size:
Observations:	Residents Identified resident Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members Residents
Record Reviews:	State reporting log Incident investigation Resident Records

Investigation Summary:

1. In interview, the NS1 denied aggressively grabbing NR1's arm. In interview, NR1 was unable to recall or speak of the allegation. Observation showed no bruising on NR 1's arm. NR1 showed no fear of NS1. In an interview, sampled residents and resident representatives denied any concerns with abuse or neglect. No failed practice

identified.
2. NR 2 declined observation of their left arm. In an interview, the ALF nurse stated the resident often runs into walls, etc that caused bruising and that she was monitored NR2's bruises. Record review showed the ALF had interventions in place to prevent reoccurrence. NR2's family representative denied any concerns with abuse or neglect. No failed practice identified.
3. In interview, NS1 and NS2 denied kicking NR3's wheelchair or abusing residents. Observation showed NR3 near NS1 and NS2 , showing no fear. In interview, Nurse Manager was unaware any incident close to the allegation had occurred. In interview, sampled residents and resident representatives denied any concerns of abuse. No failed practice identified.
4. Observation showed all memory care residents were clean and dry with clean beds. In interview, care staff stated they provided incontinent care as needed and kept residents clean and dry. No failed practice identified.
5. Record review of showed a staffing schedule where names matched time sheets. In interview, the Executive Director denied any false names on the schedule. No failed practice identified.
6. In interview, the Memory Care Director denied covering up incidents. The ALF failed to complete investigations for incidents that occurred in the Memory Care unit to rule out abuse and neglect. See Statement of Deficiencies dated 04/24/2024.

Conclusion / Action:

- ☐ 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 #: 38067
Investigator: Michelle Mcglon
Investigation Date(s): 03/11/2024 through 04/30/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 122286
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):

1. The Named Resident (NR) had been dropped at the Assisted Living Facility (ALF), resulting in injuries.
2. The NR's arm has been caught in their wheelchair and gait belt, resulting in injuries.
3. The NR had pressure ulcers, due to the ALF staff not putting the air loss wafer on the bed.
4. The ALF staff were not providing incontinence care or repositioning the NR.
5. The NR's family representative was physically and verbally attacked by an aggressive resident at the ALF.
6. The NR's family has requested staff sit near the resident's room to guard from aggressive residents, the ALF did not heed the request.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 4 Closed records sample size:
Observations:	Residents Staff to resident interactions Resident to resident interactions Resident rooms
Interviews:	Nursing staff Identified resident Family members
Record Reviews:	State reporting log Incident investigation Resident Records

Investigation Summary:

1. Interview and record review showed the ALF staff did not drop the NR. The NR had a fall, resulting in injuries while receiving care from an outside provider. The ALF completed an investigation and ruled out abuse and neglect. Interventions were put in to place to prevent reoccurrence. Sample resident representatives reported no

concerns with care. The ALF failed to complete an updated assessment to include the NR's current care needs. See Statement of Deficiencies dated 04/24/2024.
2. Record review showed the NR had a new diagnosis affecting the resident's cognition and function including right-sided weakness causing their hand to drop. In interview, the Nurse Manager stated the NR did get a skin tear that could have been caused by the wheelchair, first aid was applied. The NR was no longer using the wheelchair and was bed bound. The ALF failed to complete an updated assessment to include the NR's current care needs and skin issues. See Statement of Deficiencies dated 04/24/2024.
3. Interview and record review showed the NR had orders for turning and repositioning. In interview the staff stated the NR's family often refused turning and repositioning care. Record review showed no order for an air loss wafer for the mattress. A third-party provider was monitoring and treating skin issues. The ALF failed to complete an updated assessment to include the NR's current care needs and skin issues. See Statement of Deficiencies dated 04/24/2024.
4. Observation showed the NR was clean and dry. Record review showed an order to provide incontinence care and repositioning a specific times. Record review showed the ALF were not to change or reposition the NR from midnight to 6:00 AM. The ALF staff reported offering incontinence care and repositioning for the NR that was refused by the NR's representative. The ALF failed to complete an updated assessment to include the NR's current care needs and incontinence issues. See Statement of Deficiencies dated 04/24/2024.
5. Record review and interview showed the aggressive resident had a history of incidents. Record review showed the MCD failed to complete an investigation to determine the circumstances surrounding disruptive behaviors or implement interventions to re-direct and monitor the NR. Failed practice identified WAC 388-78A-2371(1)(2)(3)(4). See Statement of Deficiencies dated 04/24/2024.
6. Record review showed appropriate staffing ratios in the Memory Care Unit. Observation showed the staff re-directing residents as needed. The ALF did not provide "guarding" and the NR's records do not indicate a need for one-on-one care. No failed practice identified.

Conclusion / Action:

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

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.

The department completed data collection for an unannounced on-site complaint investigation on 03/11/2024 and 03/11/2024 of:

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

This document references the following complaint number(s): 122123, 121833, 120746, 120068, 119695, 122828, 122286

The following sample was selected for review during the unannounced on-site visit: 4 of 49 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

05/07/2024
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) May 8, 2024 Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to update the Assessment for 1 of 1 sampled resident (Resident 1) for a change of condition. This failure resulted in a Resident 's Assessment that did not identify their current care needs and placed them at risk of not receiving the appropriate care and services.

Findings included...

NOTE: Washington Administrative Code (WAC) 388-78A-2090 - Full assessment topics. (1) Individual's recent medical history, including, but not limited to: (a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons; (b) Chronic, current, and potential skin conditions; or (2) Currently necessary and contraindicated medications and treatments for the individual, including: (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including: (c) Other conditions that may require behavioral intervention strategies; (d) Individual's ability to leave the assisted living facility unsupervised; and (7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of: (c) Dementia. While screening a resident for dementia, the assisted living facility must: (i) Base any determination that the resident has short-term memory loss upon objective evidence; and (ii) Document the evidence in the resident's record. (d) Other conditions affecting cognition, such as traumatic brain injury. (8) Individual's level of personal care needs, including: (a) Ability to perform activities of daily living; (9) Individual's activities, typical daily routines, habits and service preferences.

Resident 1

Administrator (or Representative) Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF) failed to update the Assessment for 1 of 1 sampled resident (Resident 1) for a change of condition. This failure resulted in a Resident 's Assessment that did not identify their current care needs and placed them at risk of not receiving the appropriate care and services.

Findings included...

NOTE: Washington Administrative Code (WAC) 388-78A-2090 - Full assessment topics. (1) Individual's recent medical history, including, but not limited to: (a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons; (b) Chronic, current, and potential skin conditions; or (2) Currently necessary and contraindicated medications and treatments for the individual, including: (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including: (c) Other conditions that may require behavioral intervention strategies; (d) Individual's ability to leave the assisted living facility unsupervised; and (7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of: (c) Dementia. While screening a resident for dementia, the assisted living facility must: (i) Base any determination that the resident has short-term memory loss upon objective evidence; and (ii) Document the evidence in the resident's record. (d) Other conditions affecting cognition, such as traumatic brain injury. (8) Individual's level of personal care needs, including: (a) Ability to perform activities of daily living; (9) Individual's activities, typical daily routines, habits and service preferences.

Resident 1

Record review of an undated Face sheet, showed the ALF admitted Resident 1 on [redacted]/2024 with multiple medical diagnoses. Record review of an Assessment, dated 12/20/2023, showed Resident 1 was continent of bowel and bladder, had no history of falls, ate a diet of no added salt diet with a regular texture, had no current or chronic wounds, and self-administered of all medications.

Review of a Progress Note (PN), dated 01/24/2024, showed Staff B (Registered Nurse) documented Resident 1 was diagnosed with a [redacted].

In an interview, on 03/14/2024 at 2:40 PM, Staff B stated that since Resident 1 was diagnosed with the [redacted] they had a significant change of condition and declining cognitive function requiring more care. Staff B stated Resident 1 had a pressure injury on their coccyx (tailbone). Staff B stated that Resident 1 had a fall with the former hospice aide resulting in multiple skin injuries. Staff B stated that Resident 1's family representative was now administering all medications to the resident. Staff B stated that Resident 1 was now bed bound, on a turning schedule and incontinent.

Record review a PN, dated 01/10/2024, showed that Resident 1 was seen by home health due to declining cognitive function. A PN, dated [redacted]/2024, showed Resident 1 has a fall and was transported to the emergency department for evaluation, then hospitalized. A PN, dated 02/01/2024, showed Staff B documented Resident 1 had "right side neglect due to brain mass and right hand will drop." A PN, dated 02/15/2024, Staff E (Medication Technician) documented Resident 1 had a fall, while receiving a shower from a hospice aide resulting in multiple open areas to her arms and legs. A PN, dated 02/22/2024, showed Resident 1 was on alert charting for open area to her coccyx.

Record review of a faxed Physician's Order, dated 03/06/2024, showed that the ALF were to provide Resident 1 supplemental oxygen for comfort, a pureed diet with nectar thickened liquids, and an incontinence and turning/reposition schedule.

Record review showed the ALF had not updated Resident 1's Assessment since 12/20/2023. The Assessment was not updated to reflect Resident 1's changes in diet, fall risk, incontinent care, medication management, turning and repositioning schedules, or wound care.

This deficiency was previously cited on 05/20/2021.

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) June 14, 2024.

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

Administrator (or Representative) May 8th, 2024 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 observation, interview, and record review, the Assisted Living Facility (ALF) failed to complete investigations, determine the circumstances surrounding an incident or accident affecting the residents health or safety, put interventions in place to prevent reoccurrence, and protect the resident during the course of the investigation for 2 of 4 sampled residents (Resident 2 and 3). These failures placed Resident 2 and 3 at risk of abuse, neglect, and further injuries.

Finding included...

Record review of the ALF's Occurrence Reporting Policy, dated 07/17/2023, showed "it is the expectation of this community that all resident occurrences, defined as any incident involving a resident or resident(s) that is out of the ordinary or unusual to that resident, will be documented, investigated and reported as applicable and appropriate resident specific measures put in place reduce the risk of re-occurrence and/or serious injury."

Resident 2
Record review of a RSP (Resident Service Plan equivalent to Negotiated Service Agreement), dated 02/21/2024, showed the ALF admitted Resident 2 on [redacted]/2024 with multiple medical diagnoses including [redacted]

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

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 observation, interview, and record review, the Assisted Living Facility (ALF) failed to complete investigations, determine the circumstances surrounding an incident or accident affecting the residents health or safety, put interventions in place to prevent reoccurrence, and protect the resident during the course of the investigation for 2 of 4 sampled residents (Resident 2 and 3). These failures placed Resident 2 and 3 at risk of abuse, neglect, and further injuries.

Finding included...

Record review of the ALF's Occurrence Reporting Policy, dated 07/17/2023, showed "it is the expectation of this community that all resident occurrences, defined as any incident involving a resident or resident(s) that is out of the ordinary or unusual to that resident, will be documented, investigated and reported as applicable and appropriate resident specific measures put in place reduce the risk of re-occurrence and/or serious injury."

Resident 2
Record review of a RSP (Resident Service Plan equivalent to Negotiated Service Agreement), dated 02/21/2024, showed the ALF admitted Resident 2 on [redacted]/2024 with multiple medical diagnoses including [redacted].

Record review of the Department's Secure Tracking and Reporting System (STARS) database, on 04/16/2024 at 8:00 AM, showed the ALF reported Resident 2 had eloped from the memory care unit (MCU) on 02/20/2024. Record review of the Department's STARS database showed a separate report, dated 03/06/2024, that showed Resident 2 had been disruptive and had thrown furniture on the memory care unit breaking a window.

In an interview, on 03/14/2024 at 2:01 PM, Staff E (Medication Technician) confirmed the incident when Resident 2 was aggressive and threw a piece of furniture that broke the glass door leading into the chart room. Staff E stated that the police were called, and Resident 2 was taken to jail but later returned.

Record review showed no documentation of investigations regarding Resident 2's elopement and disruptive behavior event of throwing furniture. There was no documentation to rule out abuse and neglect, there was no information determining the circumstances or events that resulted in the elopement or disruptive behavior, there was no documentation on needed or implemented measures to prevent further incidents, and there was no documentation on what was done to protect other residents from Resident 2's actions.

On 03/14/2024 at 2:05 PM, the Department Representative requested the two separate investigative documents for Resident 2's elopement and disruptive behavior event of throwing furniture.

In an interview, on 04/16/2024 at 10:25 AM, Staff C (Memory Care Director) stated that she did not conduct or complete investigations for Resident 2's elopement or disruptive behavior. Staff C stated that she did not think an investigation was necessary.

Resident 3
Record review of a RSP, dated 02/22/2024, showed the ALF admitted Resident 3 on [redacted]/2023 with multiple medical diagnoses including [redacted].

Record review of the Department's STARS database, on 04/15/2024 at 3:40 PM, showed the facility reported that, on 02/17/2024, Resident 3 had been pushed by another resident resulting in a right hip fracture and laceration (cut) on the head.

Record review of a Resident Occurrence Report (ROR), dated 02/17/2024, documented that Resident 3 was found on the floor in the common area. The ROR stated Resident 3 reported to the ALF staff that a female resident in a blue coat (describing Resident 4) had pushed her. The ROR "abuse was ruled out, resident [3] was last seen 10 minutes prior to event."

Record review showed the ROR documentation of Resident 3 being pushed by Resident 4 did not determine the circumstances of the incident, only describing when the Resident 3 was last seen. There was no information documenting what happened that resulted in Resident 3's fall with injury, there was no documentation on needed or implemented

measures to prevent further incidents, and there was no documentation on what was done or if intervention were needed to protect other residents from Resident 4.

In an interview, on 04/15/2024 at 10:25 AM, Staff C stated that she knew her investigations needed some work. Staff C stated she ruled out abuse only because nothing had previously happened between Resident 3 and 4. Staff C stated she did not interview Resident 4 during the investigation.

This is a recurring deficiency previously cited on 08/17/2021, 01/30/2023, 03/30/2023, and 09/28/2023.

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) June 14 · 2024 .

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

Administrator (or Representative) Date: May 8, 2024

measures to prevent further incidents, and there was no documentation on what was done or if intervention were needed to protect other residents from Resident 4.

In an interview, on 04/15/2024 at 10:25 AM, Staff C stated that she knew her investigations needed some work. Staff C stated she ruled out abuse only because nothing had previously happened between Resident 3 and 4. Staff C stated she did not interview Resident 4 during the investigation.

This is a recurring deficiency previously cited on 08/17/2021, 01/30/2023, 03/30/2023, and 09/26/2023.

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