



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

08/05/2025

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 # 1995

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 62524 (Completion Date 08/05/2025) and 58868 (Completion Date 06/09/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/05/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(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 :

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

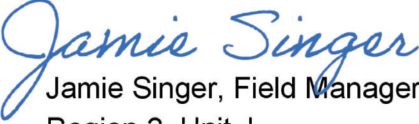
WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

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

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, 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 #: 47703

Investigator: Michelle Mcglon

Investigation Date(s): 09/24/2024 through 11/06/2024

Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 147010

Region/Unit #: RCS Region 2 / Unit J

Allegation(s):

1. The Named Staff (NS) did not know how to transcribe new physician's orders, resulting in Named Resident (NR) not receiving the correct medications.

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 2 Closed records sample size: 1
Observations:	Residents Resident rooms Staff to resident interactions
Interviews:	Nursing staff Executive Director Family members
Record Reviews:	State reporting log Resident Records

Investigation Summary:

1. Interview and record review showed the ALF failed to administer medications as ordered. In an interview, the NS stated that the orders were confusing. The NS did not seek clarification resulting in new physician's orders not being implemented. See Statement of Deficiency WAC 388-78A-2210.

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 #: 47703

Investigator: Michelle Mcglon

Investigation Date(s): 09/24/2024 through 11/06/2024

Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 149368

Region/Unit #: RCS Region 2 / Unit J

Allegation(s):

1. An unknown resident was roaming the halls and trying to leave the Assisted Living Facility (ALF).
2. Named Resident (NR) received a double dose of medication at the ALF.
3. Named Resident 1 (NR1) was not receiving their insulin as ordered.
4. The ALF Medication Technician (MT) were poorly trained
5. The ALF was understaffed.

Investigation Methods:

Sample:	Total residents: 57 Resident sample size: 2 Closed records sample size: 1
Observations:	Residents Staff to resident interactions Resident to resident interactions Medications
Interviews:	Residents Nursing staff
Record Reviews:	State reporting log Resident Records

Investigation Summary:

1. The ALF staff were not aware of an unknown resident roaming the halls and trying to elope, unable to substantiate. No failed practice identified.
2. Interview and record review showed the NR was receiving the correct doses of medications. In an interview, the Assisted Living Director (ALD) stated that the NR was receiving a different doses of medication while in skilled nursing. No failed practice identified.
3. Interview and record review showed the ALF failed to ensure insulin was available resulting in missed doses. Failed practice identified. See Statement of Deficiency WAC 388-78A-2240 and WAC 388-78A-2350.
4. Record review and interview showed the ALF MT was trained to pass medications.

Observation showed the MT passing the appropriate medications at the correct time. No failed practice identified.

5. Observation showed the ALF had staff and the ALD was providing care. In an interview, the ALD stated that they filled open shifts. No failed practice.

Conclusion / Action:

- ☒ 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

Statement of Deficiencies	License #: 1995	Compliance Determination # 58868
Plan of Correction	NORTH CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 1 of 6	Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING	06/09/2025
COMMUNITY LLC		

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 05/14/2025, 05/29/2025, 06/02/2025 and 04/30/2025 of:

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

This document references the following SOD dated: 06/09/2025

The following sample was selected for review during the unannounced on-site visit: 4 of 59 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

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

Statement of Deficiencies	License #: 1995	Compliance Determination # 58868
Plan of Correction	NORTH CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 2 of 6	Licenses: NORTH CREEK RETIREMENT & ASSISTED LIVING	06/09/2025
	COMMUNITY LLC	

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

06/24/2025
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.

John Marger

Administrator (or Representative)

6/30/25

Date

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(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 :

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure safe medication services were implemented for 1 of 4 sampled residents (Resident 1) when they did not receive medications as prescribed by a physician. This failure resulted in Resident 1 not receiving a physician's ordered medication and place them at risk for medical complications.

Findings included...

Review of the Department's Secured Tracking and Reporting System (STARS) database, on 06/02/2025, showed the ALF had been cited under this regulation on 03/29/2023, 06/26/2023, 03/14/2024, 11/06/2024 and 03/05/2025. The Statement of Deficiencies (SOD) issued by the Department on 03/05/2025, included Plan of Correction (POC) with

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	06/24/2025 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)

Date

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

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(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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure safe medication services were implemented for 1 of 4 sampled residents (Resident 1) when they did not receive medications as prescribed by a physician. This failure resulted in Resident 1 not receiving a physician's ordered medication and place them at risk for medical complications.

Findings included...

Review of the Departments Secured Tracking and Reporting System (STARS) database, on 06/02/2025, showed the ALF had been cited under this regulation on 03/29/2023, 06/26/2023, 03/14/2024, 11/06/2024 and 03/05/2025. The Statement of Deficiencies (SOD) issued by the Department on 03/05/2025, included Plan of Correction (POC) with

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

a Plan/Attestations Statement stating, "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, (ALF) 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." The POC was signed by the ALF's representative stating they would be in compliance with this regulation by 04/19/2025.

Review of STARS showed the Department imposed conditions on the ALFs license with the SOD issued on 03/05/2025.

- The licensee must hire, at their own expense, a Registered Nurse Consultant (RNC) not currently or previously associated with the facility no later than April 3rd, 2025, who is familiar with assisted living facility regulations, to assist with the following:

Assess the current medication system and if necessary, develop a new system or modify the existing system to comply with all applicable medication regulations for assisted living facilities to include but not limited to WAC 388-78A-2210.

o Train all current staff performing as medication technicians in the new or updated medication system to ensure a clear understanding of safe medication delivery and to ensure residents receive medications as prescribed.

o Audit the medication delivery system weekly until such a time as the facility can demonstrate sustained compliance with WAC 388-78A-2210.

NOTE: According to mayoclinic.org a urinary tract infection (UTI) is an infection in any part of the urinary system. The urinary system includes the kidneys, ureters, bladder and urethra. Most infections involve the lower urinary tract — the bladder and the urethra. But left untreated, UTIs can cause serious health problems. Some of the complications may include repeated infections, permanent kidney damage from an untreated UTI, and sepsis (a potentially life-threatening complication of an infection).

NOTE: According to medicalnewstoday.com, the effectiveness of antibiotic treatment depends on a person taking the medication correctly. Missing several doses of antibiotic can result in ineffective treatment and potentially contribute to antimicrobial resistance. Antibiotics are essential medications that doctors prescribe to help prevent and treat bacterial infections. When a doctor prescribes a course antibiotic, it is essential that they try to take the course as the doctor advises.

Record review of a Resident Service Plan (RSP-equivalent to a Negotiated Service Plan), dated 04/15/2025, showed the ALF admitted Resident 1 on [REDACTED]/2025 with multiple medical diagnoses. Record review of a signed physician's order, dated [REDACTED]/2025, showed that Resident 1 could not manage or self-administer as needed (PRN), prescription, and over the counter medications.

Statement of Deficiencies	License #: 1995	Compliance Determination # 58868
Plan of Correction	NORTH CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 4 of 6	Licenses: NORTH CREEK RETIREMENT & ASSISTED LIVING	06/09/2025
COMMUNITY LLC		

Record review of a hospital After Visit Summary (AVS), dated 04/14/2025, showed that Resident 1 was evaluated for a urinary tract infection and a chronic eye infection. The AVS showed Resident 1 had new physician's orders for cephalexin (an antibiotic used to treat urinary tract infections) 500 milligrams (mg), take one capsule by mouth three times daily for five days; tobramycin (used in the eye to treat bacterial infections of the eye) 0.3% ophthalmic solution, administer one drop into both eyes every four hours for seven days.

Record review of an April 2025 MAR showed Resident 1 only received one dose of the cephalexin on 04/17/2025, missed all three doses 04/19/2025 and 04/20/2025, and only received one dose on 04/21/2025. Review of the April 2025 MAR showed the tobramycin was never transcribed on to the MAR or administered as ordered to Resident 1 for the chronic eye infection.

In an interview, on 04/30/2025 at 2:50 PM, Staff A (Assisted Living Director) confirmed medication was not administered to Resident 1 as prescribed.

In an interview, on 06/09/2025 at 12:35 PM, Collateral Contact 1 (CC1-Registered Nurse (RN) Consultant) stated that the ALF staff were not monitoring residents for missed medications. CC1 stated that the ALF had not added parameters for as-needed (PRN) medications given to hospice residents. CC1 stated that the facility continued to require RN consultant oversight.

This is an uncorrected deficiency previously cited on 03/05/2025 and 11/06/2024 and a recurring deficiency previously cited on 03/29/2023, 06/26/2023, 03/14/2024.

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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 7/24/25 *[Signature]*

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

Tou Mangan
Administrator (or Representative)

6/30/25
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

Record review of a hospital After Visit Summary (AVS), dated 04/14/2025, showed that Resident 1 was evaluated for a urinary tract infection and a chronic eye infection. The AVS showed Resident 1 had new physician's orders for cephalexin (an antibiotic used to treat urinary tract infections) 500 milligrams (mg), take one capsule by mouth three times daily for five days; tobramycin (used in the eye to treat bacterial infections of the eye) 0.3% ophthalmic solution, administer one drop into both eyes every four hours for seven days.

Record review of an April 2025 MAR showed Resident 1 only received one dose of the cephalexin on 04/17/2025, missed all three doses 04/19/2025 and 04/20/2025, and only received one dose on 04/21/2025. Review of the April 2025 MAR showed the tobramycin was never transcribed on to the MAR or administered as ordered to Resident 1 for the chronic eye infection.

In an interview, on 04/30/2025 at 2:50 PM, Staff A (Assisted Living Director) confirmed medication was not administered to Resident 1 as prescribed.

In an interview, on 06/09/2025 at 12:35 PM, Collateral Contact 1 (CC1-Registered Nurse (RN) Consultant) stated that the ALF staff were not monitoring residents for missed medications. CC1 stated that the ALF had not added parameters for as needed (PRN) medications given to hospice residents. CC1 stated that the facility continued to require RN consultant oversight.

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Plan/Attestation Statement

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

Administrator (or Representative)

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

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

timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 4 sampled residents (Resident 1 and 2) had physician's prescribed medications available in the facility. This failure placed Resident 1 and 2 at risk for health complications.

Findings included...

Record review of the ALF's policy, Ordering and Re-Ordering Medications, revised on 05/01/2023, showed the staff shall seek to always have all resident medications available. The staff should order non-cycle fill medications before the medication was down to a seven-day supply.

Record review of a Resident Service Plan, dated 04/15/2025, showed the ALF admitted Resident 1 on [REDACTED]/2025 with multiple medical diagnoses. Record review of a signed physician's order, dated [REDACTED]/2025, showed that Resident 1 could not manage or self-administer as needed (PRN), prescription, and over the counter medications. Record review of a hospital After Visit Summary (AVS), dated 04/14/2025, showed that Resident 1 was evaluated for a chronic eye infection.

Record review of an April 2025 Medication Administration Record (MAR) showed a physician's order for Refresh Tears (used to treat dry eyes and temporary relief of irritation) in each eye every four hours. The MAR showed Resident 1 did not receive Refresh Tears on 04/23/2025 and 04/24/2025. The ALF staff documented the medication had not arrived from the pharmacy and was not available.

Record review of an April 2025 MAR showed a physician's order for Senna 8.6 mg (used to treat constipation). The MAR showed Resident 1 did not receive Senna on 04/25/2025 and 04/26/2025. The ALF staff documented the medication had not arrived from the pharmacy and was not available.

RESIDENT 2

Record review of a Resident Service Plan, dated 03/23/2025, showed the ALF admitted Resident 2 on [REDACTED]/2023 with multiple medical diagnoses. The RSP showed the ALF staff were to prepare and deliver medication per physician's orders.

Record review of an April 2025 MAR showed a physician's order for citalopram (used to

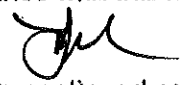
Statement of Deficiencies	License #: 1995	Compliance Determination # 58868
Plan of Correction	NORTH CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 6 of 6	Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC	06/09/2025

(treat depression) 20 mg by mouth daily. The MAR showed Resident 2 did not receive citalopram on 04/19/2025 and 04/20/2025. The ALF staff documented the medication had not arrived from the pharmacy,

In an interview, on 04/30/2025 at 2:30 PM, Staff A (Assisted Living Director) stated that Medication Technician (MT) don't always look for the medications. The MTs will document the medication was not available instead of looking for it.

This is an uncorrected citation previously cited on 03/05/2025 and 11/06/2024 and recurring previously cited on 08/22/2023.

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) 7/8/25 . 7/24/25 

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



Administrator (or Representative)

6/30/25

Date

treat depression) 20 mg by mouth daily. The MAR showed Resident 2 did not receive citalopram on 04/19/2025 and 04/20/2025. The ALF staff documented the medication had not arrived from the pharmacy.

In an interview, on 04/30/2025 at 2:30 PM, Staff A (Assisted Living Director) stated that Medication Technician (MT) don't always look for the medications. The MTs will document the medication was not available instead of looking for it.

This is an uncorrected citation previously cited on 03/05/2025 and 11/06/2024 and recurring previously cited on 08/22/2023.

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



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 #52547
Plan of Correction	NORTH CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 1 of 6	Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING	03/05/2025
COMMUNITY LLC		

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 01/28/2025, 02/12/2025 and 01/03/2025 of:

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

This document references the following SOD dated: 03/05/2025

The following sample was selected for review during the unannounced on-site visit: 3 of 57 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

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Statement of Deficiencies	License #: 1995	Compliance Determination #52547
Plan of Correction	NORTH CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 2 of 6	Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING	03/05/2025
	COMMUNITY LLC	

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

03/18/2025
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.

[Signature]
Administrator (or Representative)

3/22/25
Date

WAC 388-78A-2210 Medication services:

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

(a) Meet the requirements of chapter 89.41 RCW Legend drugs, Prescription drugs, and other applicable statutes and administrative rules; and

(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:

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 4 sampled residents (Resident 1) received their medications as prescribed by a physician. This failure resulted in Resident 1 not receiving a physician's ordered medications to treat an infection.

Findings included...

Record review of a Resident Service Plan (RSP), dated 11/26/2024, showed the ALF admitted Resident 1 on [REDACTED] 2024 with multiple medical diagnoses. Record review of Resident 1's Hospice IDG Comprehensive Assessment showed the resident was admitted to hospice (end of life care) services on 12/12/2024.

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

03/18/2025

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)

Date

WAC 388-78A-2210 Medication services.

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

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Findings included...

Record review of a Resident Service Plan (RSP), dated 11/26/2024, showed the ALF admitted Resident 1 on [REDACTED] 2024 with multiple medical diagnoses. Record review of Resident 1's Hospice IDG Comprehensive Assessment showed the resident was admitted to hospice (end of life care) services on 12/12/2024.

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

Statement of Deficiencies	License # 1995	Compliance Determination # 52547
Plan of Correction	NORTH CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 3 of 6	Licenses: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC	03/05/2025

Record review of a Physician Order (PO), dated 12/31/2024, showed Resident 1 was to receive Cipro (an antibiotic) 500 milligram (mg) twice a day for three days, for a urinary tract infection (UTI).

Record review of a December 2024 and January 2025 Medication Administration Records (MAR) did not reflect that the Cipro was transcribed or administered as ordered to Resident 1 for the UTI.

In an interview, on 01/28/2025 at 4:50 PM, Staff A (Executive Director) confirmed Resident 1 did not receive the Cipro as ordered and stated that she does not know how it was missed.

This is an uncorrected deficiency previously cited on 11/06/2024 and a recurring deficiency previously cited on 03/29/2023, 08/26/2023, 03/14/2024.

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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 4-19-25.

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


Administrator (or Representative)

3/22/25
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 3 of 4 sampled residents (Resident 1, 2, and 3) had medications available in the facility. This failure placed Resident 1, 2, and 3 at risk for health complications.

Findings included...

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This is an uncorrected deficiency previously cited on 11/06/2024 and a recurring deficiency previously cited on 03/29/2023, 06/26/2023, 03/14/2024.

Plan/Attestation Statement

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Date

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Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 4 sampled residents (Resident 1, 2, and 3) had medications available in the facility. This failure placed Resident 1, 2, and 3 at risk for health complications.

Findings included...

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

Record review of the ALF's policy, Ordering and Re-Ordering Medications, revised on 05/01/2023, showed the staff shall seek to always have all resident medications available. The staff should order non-cycle fill medications before the medication was down to a seven-day supply.

RESIDENT 1

Record review of a Resident Service Plan (RSP), dated 11/26/2024, showed the ALF admitted Resident 1 on [REDACTED]/2024 with multiple medical diagnoses including [REDACTED]. Record review of the RSP showed the ALF was to provide medication administration and Resident 1 did not have a good understanding of their medications.

Record review of a January 2025 Medication Administration Record (MAR) showed a physician's order for Humalog (an insulin that controls blood sugar levels in a person with diabetes) to be administered three times a day. The MAR showed Resident 1 did not receive their insulin from 01/20/2025 through 01/23/2025. Resident 1 missed 10 doses of Humalog. The ALF staff documented the medication had not arrived from the pharmacy and was not available.

Record review of a January 2025 MAR showed a physician's order for metoprolol 25 milligrams (mg) (used to high blood pressure). The MAR showed Resident 1 did not receive metoprolol from 01/04/2025 through 01/16/2025. The ALF staff documented the medication had not arrived from the pharmacy and was not available.

Record review of a January 2025 MAR showed a physician's order for levothyroxine 88 micrograms (used to treat hypothyroidism). The MAR showed Resident 1 did not receive levothyroxine on 01/03/2025. The ALF staff documented the medication had not arrived from the pharmacy and was not available.

Record review of a January 2025 MAR showed a physician's order for Januvia 50 mg (used to treat diabetes) to be given daily. The MAR showed Resident 1 did not receive Januvia from 01/03/2025 through 01/12/2025. The ALF staff documented the medication had not arrived from the pharmacy and was not available.

Record review of a January 2025 MAR showed a physician's order for citalopram 10 mg (used to treat depression) to be given daily. The MAR showed Resident 1 did not receive citalopram from 01/24/2025 through 01/28/2025. The ALF staff documented the medication had not arrived from the pharmacy and was not available.

In an interview, on 02/20/2025 at 3:57 PM, Collateral Contact 1 (Family Representative) stated that the ALF had not notified them when medications were not available from the pharmacy.

RESIDENT 2

Record review of an Assessment, dated 09/17/2024, showed the ALF admitted Resident 2 on [REDACTED]/2023 with multiple medical diagnoses. The Assessment showed that Resident 2 was on hospice (end of life) for comfort care and pain management.

Record review of a January 2025 MAR showed a physician's order for acetaminophen 500 mg (used treat minor aches and pain) two tablets twice a day. The MAR showed Resident 2 did not receive acetaminophen from 01/02/2025 through 01/14/2025. The ALF staff documented the medication had not arrived from the pharmacy and was not available.

Record review of a January 2025 MAR showed a physician's order for omeprazole 40 mg (used to treat heartburn). The MAR showed Resident 2 did not receive omeprazole from 01/01/2025 through 01/07/2025. The ALF staff documented the medication had not arrived from the pharmacy and was not available.

RESIDENT 3

Record review of an undated Face sheet, showed the ALF admitted Resident 3 on [REDACTED]/2025 with multiple medical diagnoses. Record review of Charting Notes, dated [REDACTED]/2025, showed resident 3 was admitted to hospice.

Record review of a January 2025 MAR showed a physician's order for Sotalol 20 mg (used to treat heart problems) twice a day. The MAR showed Resident 3 did not receive Sotalol from 01/07/2025 through 01/09/2025. The ALF staff documented the medication had not arrived from the pharmacy and was not available.

In an interview, on 01/28/2025 at 12:57 PM, Staff A (Executive Director) confirmed the ALF did not obtain medications in a timely manner for Residents 1, 2, and 3 and the medications were not available.

This is an uncorrected citation previously cited on 11/06/2024 and recurring previously cited on 08/22/2023.

Statement of Deficiencies	License # 1895	Compliance Determination # 52547
Plan of Correction	NORTH CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 6 of 6	Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC	03/05/2025

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) 4-19-25

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



Administrator (or Representative)

3-22-25

Date

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

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



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 # 47703
Plan of Correction	NORTH CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 1 of 7	Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC	11/06/2024

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 09/24/2024, 09/27/2024, 10/21/2024, 10/22/2024, 11/04/2024 and 11/04/2024 of:

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

This document references the following complaint number(s): 147010, 149368

The following sample was selected for review during the unannounced on-site visit: 2 of 57 current residents and 1 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.


Residential Care Services

11/13/2024
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.

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


Administrator (or Representative)

11/19/2024
Date

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(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 :

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 3 sampled residents (Resident 1) received their medications as prescribed by a physician. This failure resulted in Resident 1 missing scheduled medications at the end of life.

Findings included...

Record review of an Assessment, dated 09/04/2024, showed the ALF admitted Resident 1 on [REDACTED]/2024 with multiple medical diagnoses. Record review of Resident 1's Progress Notes showed the resident was admitted to hospice (end of life care) services on 08/30/2024.

Record review of a Physician Order (PO), dated 08/30/2024, showed Resident 1 was to receive acetaminophen 1,000 milligrams (mg) every eight hours for pain management.

Record review of an August 2024 and September 2024 Medication Administration Record (MAR) did not reflect that the acetaminophen was transcribed to administer to Resident 1 for pain management.

Record review of a PO, dated 08/30/2024, showed Resident 1 was to receive senna 8.6 mg, two tablets by mouth twice a day as needed for constipation.

Administrator (or Representative)

Date

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(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 :

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 3 sampled residents (Resident 1) received their medications as prescribed by a physician. This failure resulted in Resident 1 missing scheduled medications at the end of life.

Findings included...

Record review of an Assessment, dated 09/04/2024, showed the ALF admitted Resident 1 on [REDACTED]/2024 with multiple medical diagnoses. Record review of Resident 1's Progress Notes showed the resident was admitted to hospice (end of life care) services on 08/30/2024.

Record review of a Physician Order (PO), dated 08/30/2024, showed Resident 1 was to receive acetaminophen 1,000 milligrams (mg) every eight hours for pain management.

Record review of an August 2024 and September 2024 Medication Administration Record (MAR) did not reflect that the acetaminophen was transcribed to administer to Resident 1 for pain management.

Record review of a PO, dated 08/30/2024, showed Resident 1 was to receive senna 8.6 mg, two tablets by mouth twice a day as needed for constipation.

Record review of an August 2024 and September 2024 MAR did not reflect that the senna was transcribed to administer to Resident 1 as needed for constipation until 09/05/2024.

Record review of a PQ, dated 09/07/2024, showed Resident 1 was to receive oxycodone 5 mg every four hours to be given with Haldol 1mg for pain management.

Record review of a September 2024 MAR showed the ALF did not transcribe to administer the Haldol until 09/09/2024.

In an interview, on 09/24/2024 at 8:44 AM, Collateral Contact 1 (CC1- Hospice Nurse) stated the ALF was not transcribing medications correctly on the MARs resulting in Resident 1 not receiving needed end of life medication.

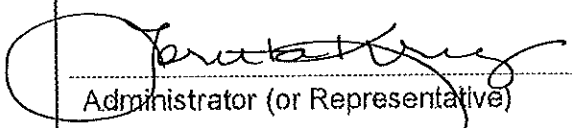
In an interview, on 09/24/2024 at 12:55 PM, Staff B stated that multiple orders were received for Resident 1. Staff B stated that the orders were confusing. Staff B denied she contacted the hospice team at any time to clarify the orders.

This is a recurring citation previously cited on 01/14/2022, 03/29/2023, 06/26/2023, 03/14/2024.

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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 12/21/24.

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



Administrator (or Representative)

11/19/24

Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(b) Respond appropriately when there are observable or reported changes in the

Record review of an August 2024 and September 2024 MAR did not reflect that the senna was transcribed to administer to Resident 1 as needed for constipation until 09/05/2024.

Record review of a PO, dated 09/07/2024, showed Resident 1 was to receive oxycodone 5 mg every four hours to be given with Haldol 1mg for pain management.

Record review of a September 2024 MAR showed the ALF did not transcribe to administer the Haldol until 09/09/2024.

In an interview, on 09/24/2024 at 8:44 AM, Collateral Contact 1 (CC1- Hospice Nurse) stated the ALF was not transcribing medications correctly on the MARs resulting in Resident 1 not receiving needed end of life medication.

In an interview, on 09/24/2024 at 12:55 PM, Staff B stated that multiple orders were received for Resident 1. Staff B stated that the orders were confusing. Staff B denied she contacted the hospice team at any time to clarify the orders.

This is a recurring citation previously cited on 01/14/2022, 03/29/2023, 06/26/2023, 03/14/2024.

Plan/Attestation Statement

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

Administrator (or Representative)

Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(7) When coordinating care or services, the assisted living facility must:

(b) Respond appropriately when there are observable or reported changes in the

resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to follow orders and notify the physician when 1 of 3 sampled resident's (Resident 2) blood sugars were outside the parameters. This failure placed Resident 2 at risk of a decline in health status.

Findings included...

Record review of a Resident Service Plan (RSP – equivalent to a Negotiated Service Agreement), dated 10/09/2024, showed the ALF admitted Resident 2 on [REDACTED]/2023 with multiple medical diagnoses including [REDACTED]. Record review of the RSP showed the ALF was to provide medication administration due to short term memory loss.

Record review of an August 2024 Medication Administration Record (MAR) showed a physician's order that the ALF was to notify the physician if Resident 2's blood sugar (BS) was less than 70 mg/dl (milligrams per deciliter) or greater than 300 mg/dl.

Record review of Resident 2's August 2024 MAR showed the resident had a BS of 310 mg/dl on 08/13/2024, a BS of 308 mg/dl on 08/17/2024, and a BS of 340mg/dl on 08/23/2024. The ALF staff documented "N", abbreviated for "No", showing the physician was not notified.

Record review of Resident 2's September 2024 MAR showed the resident had a BS of 39mg/dl on 09/18/2024, a BS of 51 mg/dl on 09/23/2024, a BS of 306 mg/dl on 09/25/2024 at 9:00 AM, and a BS of 427 mg/dl on 09/25/2024 at 6:00 PM. The ALF staff documented "N", abbreviated for "No", showing the physician was not notified.

Record review of Resident 2's October 2024 MAR showed the resident had a BS of 316 mg/dl and a BS of 443mg/dl on 10/15/2024. The ALF staff documented "N", abbreviated for "No", showing the physician was not notified.

Review of records showed no documented communication Resident 2's physician was notified regarding the BS that were outside of the parameters and requiring notification.

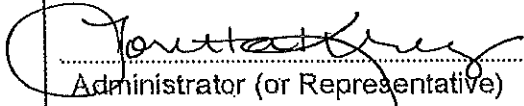
In an interview, on 11/04/2024 at 11:50 AM, Staff C (Assisted Living Director) stated that the ALF staff should have notified Resident 2's physician. Staff C stated that Resident 2's blood sugars were all over the place.

This citation was previously cited on 06/26/2023.

Plan/Attestation Statement

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


Administrator (or Representative)

11/19/24
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 2) had insulin (a medication used to lower blood sugar) available in the facility. This failure placed Resident 2 at risk for health complications.

Findings included...

Record review of the ALF's policy, Ordering and Re-Ordering Medications, revised on 05/01/2023, showed the staff shall seek to always have all resident medications available. The staff should order non-cycle fill medications before the medication was down to a seven-day supply.

Record review of a Resident Service Plan (RSP – equivalent to a Negotiated Service Agreement), dated 10/09/2024, showed the ALF admitted Resident 2 on [REDACTED]/2023 with multiple medical diagnoses including [REDACTED]. Record review of the RSP showed the ALF was to provide medication administration due to short term memory loss.

Record review of an August 2024 Medication Administration Record (MAR) showed a physician's order for Novolin N (an insulin that controls blood sugar levels in a person

This citation was previously cited on 06/26/2023.

Plan/Attestation Statement

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

Administrator (or Representative)

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 2) had insulin (a medication used to lower blood sugar) available in the facility. This failure placed Resident 2 at risk for health complications.

Findings included...

Record review of the ALF's policy, Ordering and Re-Ordering Medications, revised on 05/01/2023, showed the staff shall seek to always have all resident medications available. The staff should order non-cycle fill medications before the medication was down to a seven-day supply.

Record review of a Resident Service Plan (RSP – equivalent to a Negotiated Service Agreement), dated 10/09/2024, showed the ALF admitted Resident 2 on [REDACTED]/2023 with multiple medical diagnoses including [REDACTED]. Record review of the RSP showed the ALF was to provide medication administration due to short term memory loss.

Record review of an August 2024 Medication Administration Record (MAR) showed a physician's order for Novolin N (an insulin that controls blood sugar levels in a person

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with diabetes). The MAR showed Resident 2 did not receive their insulin from 08/10/2024 through 08/13/2024. The ALF staff documented the medication had not arrived from the pharmacy.

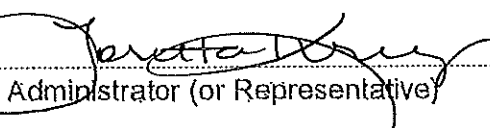
In an interview, on 11/04/2024 at 11:50 AM, Staff C (Assisted Living Director) stated that the insulin and other non-cycle fill medications should have been ordered seven days prior to running out.

This citation was previously cited on 08/22/2023.

Plan/Attestation Statement

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


Administrator (or Representative)

11/19/24
Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to include hospice (end of life care) information in the Negotiated Service Agreement (NSA) for 1 of 1 sampled resident (Resident 1). This failure placed Resident 1 at risk for not having end of life care needs met.

Findings included...

with diabetes). The MAR showed Resident 2 did not receive their insulin from 08/10/2024 through 08/13/2024. The ALF staff documented the medication had not arrived from the pharmacy.

In an interview, on 11/04/2024 at 11:50 AM, Staff C (Assisted Living Director) stated that the insulin and other non-cycle fill medications should have been ordered seven days prior to running out.

This citation was previously cited on 08/22/2023.

Plan/Attestation Statement

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

Administrator (or Representative)

Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to include hospice (end of life care) information in the Negotiated Service Agreement (NSA) for 1 of 1 sampled resident (Resident 1). This failure placed Resident 1 at risk for not having end of life care needs met.

Findings included...

Record review of an Assessment, dated 09/04/2024, showed the ALF admitted Resident 1 with multiple medical diagnoses on [REDACTED]/2024.

In an interview, on 09/24/2024 at 12:45 PM, Staff A (Registered Nurse) Resident 1 started hospice services on 08/30/2024.

Record review of a Resident Service Plan (RSP – equivalent to NSA), dated 06/27/2024, did not reflect that Resident 1 was receiving home health or hospice services.

Record review of a Temporary Service Plan (TSP), dated 09/13/2024, showed Resident 1 was nearing the end of life. The TSP did not reflect hospice information or the care they provided.

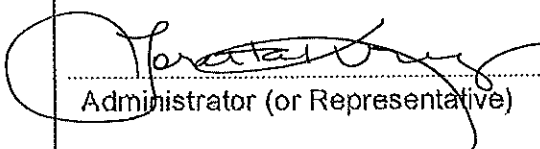
In an interview, on 09/23/2024 at 12:05 PM, Staff D (Medication Technician) stated she did not know how to contact Resident 1's hospice provider.

This citation was previously cited 09/08/2022.

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) 12/21/24.

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



Administrator (or Representative)

11/19/24

Date

Record review of an Assessment, dated 09/04/2024, showed the ALF admitted Resident 1 with multiple medical diagnoses on [REDACTED]/2024.

In an interview, on 09/24/2024 at 12:45 PM, Staff A (Registered Nurse) Resident 1 started hospice services on 08/30/2024.

Record review of a Resident Service Plan (RSP – equivalent to NSA), dated 06/27/2024, did not reflect that Resident 1 was receiving home health or hospice services.

Record review of a Temporary Service Plan (TSP), dated 09/13/2024, showed Resident 1 was nearing the end of life. The TSP did not reflect hospice information or the care they provided.

In an interview, on 09/23/2024 at 12:05 PM, Staff D (Medication Technician) stated she did not know how to contact Resident 1's hospice provider.

This citation was previously cited 09/08/2022.

Plan/Attestation Statement

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Administrator (or Representative)

Date

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