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

03/28/2025

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) 57114 (Completion Date 03/28/2025) and 52546 (Completion Date 01/28/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/28/2025 and found no deficiencies.

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

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.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(3) Not use restraints on any resident;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(5) Provide care and services to each resident in compliance with applicable state statutes related to substitute health care decision making, including chapters 7.70 , 70.122, 11.88, 11.92, and 11.94 RCW;

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

(7) Not allow any staff person to abuse or neglect any resident.

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 #: 52546
Investigator: Michelle Mcglon
Investigation Date(s): 01/03/2025 through 01/28/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 160514
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):

1. The Named Staff (NS) was physically aggressive with the Named Resident (NR) at the Assisted Living Facility (ALF).
2. The NR was threatening staff with a weapon at the ALF.
3. The ALF refused to re-admit the NR when discharged from the hospital, due to staffing ratios.

Investigation Methods:

Sample:	Total residents: 66 Resident sample size: 2 Closed records sample size:
Observations:	Residents Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members Social services staff
Record Reviews:	State reporting log Incident investigation Resident Records Facility policies Staff schedules

Investigation Summary:

1. In an interview, the NS denied being physically aggressive with the NR. Sampled staff reported no one was physically aggressive with the NR. Record review showed the ALF failed to complete occurrence report or investigation to determine the circumstances surrounding the event. Failed practice identified. See Statement of Deficiency dated 01/28/2025.
2. Staff reported the NR was aggressive, the police were called, and the resident was transported to the hospital. Record review showed the NR had a history of aggressive behavior. No failed practice identified.

3. In an interview, the Executive Director stated that staffing ratios were not the reason the NR was not re-admitted. Interview and record review showed the ALF failed to provide the NR or their family representative a written discharge or transfer notice. Failed practice identified. See Statement of Deficiency dated 01/28/2025.

Conclusion / Action:

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

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

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 01/03/2025 of:

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

This document references the following complaint number(s): 160514

The following sample was selected for review during the unannounced on-site visit: 2 of 66 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

02/06/2025
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)

2/20/25
Date

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to conduct and complete investigations determining the circumstances and documenting measures to prevent similar situations for 1 of 1 sampled resident (Resident 1) who had violent and threatening behavior towards residents. These failures contributed to Resident 1's further violent and threatening occurrences and placed the other residents at risk of harm.

Findings included...

Review of the facility's policy titled, "Occurrence Reporting Policy", dated 07/17/2023, showed the ALF would document, investigate, and report as applicable and appropriate resident specific measures put in place to reduce the risk of re-occurrence and/or serious injury.

Record review of an Assessment, dated 11/04/2024, showed the ALF admitted Resident

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Record review of an Assessment, dated 11/04/2024, showed the ALF admitted Resident

1 on [redacted]/2024 with multiple medical diagnoses including [redacted].

Record review of three Resident Occurrence Reports (ROR), showed Resident 1 had exhibited aggressive behaviors on 12/10/2024, 12/12/2024, and 12/18/2024. The RORs did not include information that attempted to determine the circumstances surrounding the incidents of aggressive behaviors or show interventions were implemented to prevent reoccurrence of aggressive behaviors and protect other residents.

Record review of a Progress Notes, dated 12/24/2024, showed Resident 1 had a fourth occurrence of behavior issues and became violent in the ALF. Resident 1 had to be transported to the hospital.

In an interview, on 12/24/2024 at 3:57 PM, Staff A (Executive Director) stated that Resident 1 had been threatening and combative that morning. Staff A stated that the ALF staff had to call the police, and Resident 1 was transported to the hospital. Staff A stated Resident 1 would not return to the facility.

In an interview, on 01/03/2025 at 1:03 PM, Staff C (Medication Technician) stated Resident 1 was aggressive and violent during the morning of 12/24/2024. Staff C stated Resident 1 had grabbed a fire extinguisher and began breaking glass. Staff C stated Resident 1 was banging on the doors of other residents and had a piece of the broken glass in their hand. Staff C stated that she and Staff D (Caregiver) had instructed the residents and a family member to keep their doors closed. Staff C stated that she was "scared" of Resident 1.

Record review showed the ALF had not initiated an ROR for the incident that occurred on 12/24/2024 involving Resident 1.

This is a recurring deficiency previously cited on 01/30/2023, 03/30/2023, 09/26/2023, and 04/30/2024.

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) 3/14/25 .

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

Administrator (or Representative) 2/20/25 Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

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(5) Provide care and services to each resident in compliance with applicable state statutes related to substitute health care decision making, including chapters 7.70 , 70.122, 11.88, 11.92, and 11.94 RCW;

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

(7) Not allow any staff person to abuse or neglect any resident.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to provide a discharge notice to 1 of 1 sampled resident (Resident 1), when the resident was transported to the hospital and not allowed to return by the facility. This failure prevented Resident 1 and their family representatives from understanding their rights related to discharge from the facility, and resulted in the resident having an extended hospital stay after being medically stable.

Findings included...

NOTE: Washington Administrative Code 388-110-100 - Disclosure, transfer, and discharge requirements. (3) Before a long-term care facility transfers or discharges a resident, the facility must: (a) First attempt through reasonable accommodations to

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Findings included...

NOTE: Washington Administrative Code 388-110-100 - Disclosure, transfer, and discharge requirements. (3) Before a long-term care facility transfers or discharges a resident, the facility must: (a) First attempt through reasonable accommodations to

avoid the transfer or discharge, unless agreed to by the resident;(b) Notify the resident and resident representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand;(c) Record the reasons in the resident's record; and(d) Include in the notice the items described in subsection (5) of this section.(4)(a) Except when specified in this subsection, the notice of transfer or discharge required under subsection (3) of this section must be made by the facility at least thirty days before the resident is transferred or discharged.(b) Notice may be made as soon as practicable before transfer or discharge when:(i) The safety of individuals in the facility would be endangered;(ii) The health of individuals in the facility would be endangered;(iii) An immediate transfer or discharge is required by the resident's urgent medical needs; or(iv) A resident has not resided in the facility for thirty days.(5) The written notice specified in subsection (3) of this section must include the following:(a) The reason for transfer or discharge;(b) The effective date of transfer or discharge;(c) The location to which the resident is transferred or discharged;(d) The name, address, and telephone number of the state long-term care ombuds;(6) A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. (7) A resident discharged in violation of this section has the right to be readmitted immediately upon the first availability of a gender-appropriate bed in the facility.

Record review of an Assessment, dated 11/04/2024, showed the ALF admitted Resident 1 on [redacted]2024 with multiple medical diagnoses including [redacted].

In an interview, on 12/24/2024 at 3:57 PM, Staff A (Executive Director) stated that Resident 1 had been threatening and combative that morning. Staff A stated that the ALF staff had to call the police, and Resident 1 was transported to the hospital. Staff A stated Resident 1 would not return to the facility.

Record review showed the ALF had no discharge/transfer notification in writing.

In an interview, on 01/17/2025 at 9:05 AM, Collateral Contact 1 (CC1-Family Representative) stated that the ALF had not provided them with a written discharge/transfer notice that Resident 1 could not return to the facility.

In an interview, on 01/17/2025 at 1:26 PM, Collateral Contact 2 (CC2-Hospital Representative) stated that the ALF did send a written discharge/transfer notice to Resident 1 while they were hospitalized.

In an interview, on 01/17/2025 at 1:56 PM, Staff B (Assistant Executive Director) stated that she did not believe a discharge/transfer notice was given to Resident 1 or their family representative.

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Administrator (or Representative) — Date: 2/20/25

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