STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 71648 (Completion Date 02/03/2026) and 68030 (Completion Date 11/24/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/03/2026 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-2600-1-b, WAC 388-78A-2600-2-d, WAC 388-78A-2600-2-f

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 #: 68030
Investigator: Michelle Mcglon
Investigation Date(s): 10/23/2025 through 11/24/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 197649
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):
1. The Named Resident (NR) was found unresponsive without vital signs, resulting in staff not immediately call 911.

Investigation Methods:

Sample:	Total residents: 43 Resident sample size: Closed records sample size: 1
Observations:	Residents Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members
Record Reviews:	State reporting log Incident investigation Facility policies Resident Records

Investigation Summary:
1. Interview and record review showed the ALF failed to ensure staff were trained on the policy and procedures when finding an unresponsive resident. In an interview, care staff reported not knowing the next steps after finding the NR without vital signs. Record review showed the ALF care staff waited several hours before calling 911. Failed practice identified. See Statement of Deficiency WAC 388-78A-2600 (1)(d)(2)(b)(f)

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

Statement of Deficiencies	License #: 1995	Compliance Determination # 68030
Plan of Correction	NORTH CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 1 of 5	Licensee: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC	11/24/2025

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 11/14/2025 and 10/23/2025 of:

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

This document references the following complaint number(s): 197649

The following sample was selected for review during the unannounced on-site visit: 0 of 43 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.

Jennie Swigon
Residential Care Services

11/26/2025
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)

10/4/2025
Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

(f) In response to medical emergencies;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop, implement or train care staff on their policies to call 911 immediately to pronounce death after 1 of 1 resident (Resident 1) was found unresponsive and without vital signs. This failure resulted care staff unaware of who could pronounce death and what to do if someone was found unresponsive and without vital signs, resulted in 911 not being called for an assessment/evaluation or life measures if indicated, and resulted in non-licensed staff determining Resident 1 was deceased outside of their scope of practice.

Findings included...

NOTE: According to the Revised Code of Washington (RCW) 11.95A.050 Evidence of death or status: In addition to the rules of evidence in courts of general jurisdiction, the

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Residential Care Services

Date

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Administrator (or Representative)

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Findings included…

NOTE: According to the Revised Code of Washington (RCW) 11.05A.050 Evidence of death or status: In addition to the rules of evidence in courts of general jurisdiction, the

following rules relating to a determination of death and status apply: (1) Death occurs when an individual is determined to be dead by the attending physician, county coroner, or county medical officer.

NOTE: According to the Washington Administrative Code (WAC) 246-840-830: A registered nurse may determine and pronounce death but shall not certify death as defined in RCW 70.58.160 unless the registered nurse was licensed Advance Registered Nurse Practitioner as defined in WAC 246-840-300. (1) A registered nurse may assume responsibility for the determination and pronouncement of death only if there are written policies and procedures relating to the determination and pronouncement of death in the organization with which the registered nurse is associated as an employee or by contract provided: (a) The decedent was under the care of a health care practitioner qualified to certify cause of death; and (b) The decedent was a patient of the organization with which the registered nurse is associated; and (c) There is a “do not resuscitate order” in the patient’s record when the decedent was assisted by mechanical life support systems at the time of determination and pronouncement of death. (2) A registered nurse who assumes responsibility for the determination and pronouncement of death shall be knowledgeable of the laws and regulations regarding death and human remains which affect the registered nurse’s practice of this responsibility. (3) A registered nurse who assumes responsibility for the determination and pronouncement of death shall: (a) Perform a physical assessment of the patient’s condition; (c) Document the findings of the assessment and notification in all appropriate records.

NOTE: According to nursing.wa.gov/frequently asked question, the Washington State Board of Nursing, it is not within the nursing assistant’s scope of practice to pronounce death.

Record review of the ALF policy, “Resident Death/Unresponsive Policy”, dated 08/2009, showed that the Executive Director was responsible for training staff on the appropriate procedures to follow if it was believed that a resident had expired. The policy showed that the staff were to do the following: (1) Check the resident for vital signs (breathing, pulse). If none are apparent, call 911.

Record review of an undated ALF document titled, “911 Utilization Guidelines” stated that if within the nursing scope of practice, as defined in state specific nurse practice guidance, a Registered Nurse (RN) may be able to pronounce death. The document stated in the absence of available RN 911 can be called for this task.

Record review of a Resident Service Plan (RSP), dated 04/12/2025, showed the ALF admitted Resident 1 on [redacted]/2021 with multiple medical diagnoses. The RSP did not identify Resident 1 as being on hospice care (a professional medical team focuses on comfort for patients who are no longer seeking curative treatment and have a life expectancy of six months or less. Hospice care allows a person to live with comfort and dignity; while being supported as they prepare for death). The RSP showed Resident 1 was a full code (a resident wants all possible life-saving measures, such as

cardiopulmonary resuscitation, if their heart or breathing stops).

Record review of a signed Physician Orders for Life-Sustaining Treatment (POLST), dated 05/27/2021, showed Resident 1 desired full treatment with the primary goal of prolonging life by all medically effective means.

Record review of a Resident Occurrence Report (ROR), dated [redacted]/2025, showed Resident 1 was found “passed-away” in their apartment, between 5:00 AM and 5:30 AM. The ROR stated and an unidentified caregiver found Resident 1 without no pulse, vitals, or signs of life. The ROR showed that the ALF staff did not call 911 until 1:38 PM, approximately eight hours after Resident 1 was found without vital signs.

Record review of a cellular text, sent internally to all medication technicians, titled, “NC Medtechs”, undated, showed a message sent at 5:45 AM stating that Resident 1 had, “passed away”.

In an interview, on 11/05/2025 at 1:25 PM, Staff C (Caregiver) stated that she found Resident 1 lying in bed, unresponsive. Staff C stated that she called Staff B (Medication Technician). Staff C stated that Staff B checked Resident’s carotid pulse (pulse in the neck) for approximately one minute. Staff C stated that she did not call 911. Staff C stated that both she and Staff B did not know what to do next after finding Resident 1 deceased.

Review of Washington State Provider Credential Search database showed Staff B was licensed as a Home Care Aide (HCA) and Staff C was licensed as Nursing Assistant Certified (NAC). Neither Staff B nor Staff C had active nursing credentials.

In an interview, on 11/05/2025 at 3:16 PM, Staff D (Assisted Living Director- Home Care Aide) stated that she saw a text message, while at home, from Staff B notifying her that Resident 1 was without vital signs on [redacted]/2025 around 6:30 AM. Staff D stated she arrived to the ALF around 8:30 AM and did not call 911. Staff D stated that she called Staff E (Regional Director of Operations/Interim Executive Director), on [redacted]/2025 at approximately 1:30 PM, and Staff E instructed her to call 911.

In an interview, on 11/19/2025 at 3:33 PM, when asked who could determine death of a resident Staff F (Regional Nurse) stated that information was found in the “911 Utilization Guidelines” which states directly that if within the nursing scope of practice, as defined in state specific nurse practice guidance, a Registered Nurse (RN) may be able to pronounce death. The document stated in the absence of available RN, 911 can be called for this task.

In interview, on 11/24/2025 at 9:35 AM, Staff F confirmed there was no one holding nursing credentials in the facility when Resident 1 was found unresponsive.

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) 1/08/2026 .

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

Administrator (or Representative) 12/4/2025 Date

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