



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

PSL Associates, LLC
North Point Village, Assisted Living & Memory Care
1110 E Westview Ct
Spokane, WA 99218

RE: North Point Village, Assisted Living & Memory Care License # 2479

Dear Administrator:

This letter addresses Compliance Determination(s) 66038 (Completion Date 09/23/2025) and 61069 (Completion Date 06/16/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/23/2025 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-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-1, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2210-2, WAC 388-78A-2210, WAC 388-78A-2600-1-a, WAC 388-78A-2600-1-b, WAC 388-78A-2120-1, WAC 388-78A-2120-2-b, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-1, WAC 388-78A-2320-2-a, WAC 388-78A-2320-2-b, WAC 388-78A-2320-2-c

The Department staff who did the on-site verification:

Carla Rose, NCI Community Licensors
Tethra Wales, Assisted Living Facility Licensors
Jennifer Lee, Assisted Living Facility Licensors

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Community Field Manager
Region 1, Unit B

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

North Point Village, Assisted Living & Memory Care # 2479

09/23/2025

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Residential Care Services

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



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2479	Compliance Determination # 61069
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 1 of 11	Licensee: PSL Associates, LLC	06/16/2025

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 follow-up on 06/12/2025, 06/13/2025 and 06/16/2025 of:

North Point Village, Assisted Living & Memory Care
1110 E Westview Ct
Spokane, WA 99218

This document references the following SOD dated: 06/16/2025

The following sample was selected for review during the unannounced on-site visit: 7 of 83 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

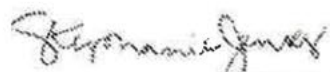
Veronica Jackson, Assisted Living Facility Licensors
Joy Pipgras, LTC Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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

Statement of Deficiencies	License #: 2479	Compliance Determination #51069
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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

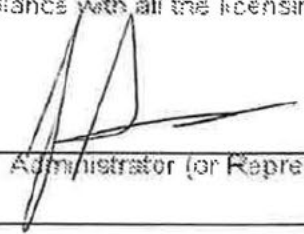


Residential Care Services

06/30/2025

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)

7/1/25
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 60A11 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
 - (b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that residents received their medication as prescribed for 2 of 7 residents (Resident 2 and 13) and failed to follow health care provider orders related to blood pressure medications for 1 of 1 resident (Resident 1) sampled for medication services. This failure resulted in delayed medication administration for Resident 13, two residents not receiving their full course of antibiotics and placed the residents at risk for health complications.

Findings included. .

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	_____ Date
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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
- (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
- (b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that residents received their medication as prescribed for 2 of 7 residents (Resident 2 and 13) and failed to follow health care provider orders related to blood pressure medications for 1 of 1 resident (Resident 1) sampled for medication services. This failure resulted in delayed medication administration for Resident 13, two residents not receiving their full course of antibiotics and placed the residents at risk for health complications.

Findings included...

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

Statement of Deficiencies	License #: 2479	Compliance Determination #81069
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
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<Resident 1>

Review of Resident 1's Negotiated Care Plan (NCP, the facility's titled negotiated service agreement), dated 05/27/2025, showed that Resident 1 had diagnoses of [REDACTED]

[REDACTED] and [REDACTED]. The care plan showed the resident had chronic diagnoses and that any changes in health condition would be reported so that new treatments could be implemented if necessary. Further review showed that the resident required assistance with medications from facility staff.

Review of Resident 1's June 2025 Medication Administration Record (MAR) showed that the resident took two medications for hypertension twice daily and each had instructions to take if the resident's blood pressure (BP). The MAR showed one medication had additional instructions with parameters to obtain the resident's heart rate (HR). Further review showed the instructions stated to notify the Health & Wellness Specialist (HWS) if the top number of blood pressure (systolic or SBP) was greater than 140 or less than 110, the bottom blood pressure number (diastolic or DBP) was greater than 90 or less than 60, or if the heart rate (HR) was greater than 100 or less than 60. Review of the MAR showed the health measurements (HR, BP, and HR) were outside of parameters and required notification to the HWS on the following dates:

Mornings: 06/02/2025 HR was 56, 06/04/2025 HR was 57, 06/05/2025 BP was 141/78, 06/06/2025 BP was 148/78, 06/08/2025 HR was 56, 06/09/2025 BP was 145/90, 06/10/2025 HR was 57, and on 06/12/2025 HR was 57.

Evenings: 06/02/2025 BP was 164/98, 06/04/2025 BP was 154/89, 06/05/2025 BP was 151/84, 06/06/2025 BP was 151/73, and on 06/09/2025 BP was 148/83.

In an interview on 06/13/2025 at 10:55 AM Staff G, Regional Health & Wellness Specialist, stated that the blood pressure parameters were ordered by the physician. Staff G further stated that staff had not notified them of the health measures that were out of parameters and that the residents' physician had not been notified.

<Resident 2>

Review of Resident 2's NCP, dated 12/23/2024, showed the resident was diagnosed with [REDACTED] and [REDACTED]. Further review showed that Resident 2 required assistance with medications from facility staff and would receive medications as they were ordered.

Review of Resident 2's Resident Notes, dated 06/05/2025, showed that the resident had a cough and cold symptoms. The notes showed that on [REDACTED]/2025 the resident had trouble breathing and was sent to the emergency room for evaluation. Further review

<Resident 1>

Review of Resident 1's Negotiated Care Plan (NCP, the facility's titled negotiated service agreement), dated 05/27/2025, showed that Resident 1 had diagnoses of [REDACTED]

[REDACTED] and [REDACTED]. The care plan showed the resident had chronic diagnoses and that any changes in health condition would be reported so that new treatments could be implemented if necessary. Further review showed that the resident required assistance with medications from facility staff.

Review of Resident 1's June 2025 Medication Administration Record (MAR) showed that the resident took two medications for hypertension twice daily and each had instructions to take the resident's blood pressure (BP). The MAR showed one medication had additional instructions with parameters to obtain the resident's heartrate (HR). Further review showed the instructions stated to notify the Health & Wellness Specialist (HWD) if the top number of blood pressure (systolic or SBP) was greater than 140 or less than 110, the bottom blood pressure number (diastolic or DBP) was greater than 90 or less than 60, or if the heartrate (HR) was greater than 100 or less than 60. Review of the MAR showed the health measurements (HR, BP, and HR) were outside of parameters and required notification to the HWD on the following dates:

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Evenings: 06/02/2025 BP was 164/98, 06/04/2025 BP was 154/89, 06/05/2025 BP was 151/84, 06/06/2025 BP was 151/73, and on 06/09/2025 BP was 148/83.

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showed that Resident 2 returned on [REDACTED] 2025 with new medication orders.

Review of Resident 2's June 2025 MAR showed a prescription for azithromycin (an antibiotic that treats infection) ordered to start on 06/08/2025 and to be given for a total of five days. Further review showed that only three days of azithromycin were administered, and that the medication was not given on 06/11/2025 or 06/12/2025.

In an interview on 06/13/2025 at 11:45 AM, Staff I, Director of Regulatory Training and Compliance, confirmed that Resident 2's June 2025 MAR showed that two days of antibiotics had not been given as prescribed.

<Resident 13>

Review of Resident 13's NCP, dated 05/03/2025, showed that Resident 13 was diagnosed with [REDACTED] and received medication assistance from facility staff.

Review of a Resident Note, dated 05/31/2025, showed that Resident 13 had an abscess (a confined pocket of pus inside the body) on their chest and was on alert charting due to receiving antibiotic treatment.

Review of Resident 13's physician's order, dated 05/30/2025, showed an order for doxycycline (an antibiotic medication for infections) twice daily for seven days.

Review of Resident 13's June 2025 MAR showed that the doxycycline had not been given to the resident until 06/04/2025, six days after being prescribed. The MAR showed that the resident had not received the full prescription. Further review showed that Resident 13 did not receive one dose on 06/08/2025, with no explanation as to the reason.

Review of Resident 13's facility investigation, dated 06/12/2025, showed that the doxycycline had not been administered when prescribed and that the facility was still investigating the reason for the delay in the medication being administered.

In an interview on 06/13/2025 at 1:36 PM, Staff G confirmed that Resident 13 did not start the doxycycline until six days from the prescription date, and that it had been a medication error.

This is an uncorrected deficiency previously cited on 04/15/2025, and a recurring deficiency previously cited on 10/04/2024 for subsections (2)(a), 08/27/2024 for subsections (1)(b), 06/04/2024 for subsections (2)(a), and 09/06/2023 for subsections (2)(a).

showed that Resident 2 returned on [REDACTED]/2025 with new medication orders.

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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 Point Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 8/14/25 9/14/2025

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

[Signature]
Administrator (or Representative)

7/1/25
Date

WAC 386-78A-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:

- (a) Maintain or enhance the quality of life for residents including resident decision-making rights;
- (b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to follow their fall program policy and procedures for 6 of 6 residents (Resident 4, 5, 7, 9, 10, and 12) sampled for falls. This failure resulted in the residents' falls not being tracked to potentially decrease further risk and placed the residents at risk of harm.

Review of the facility's policy titled, "Fall Management and Recovery, subsection Tracking and Trending," dated 01/2025, showed that the facility would review the number of resident falls for the week during the Weekly at Risk Meeting.

<Resident 4>

Review of a facility incident report/investigation, dated 06/05/2025, showed that Resident 4 had a fall that resulted in a fractured vertebra (back).

<Resident 5>

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 Point Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date)_____.

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Administrator (or Representative)

Date

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<Resident 4>

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<Resident 5>

Statement of Deficiencies	License #: 2479	Compliance Determination #81089
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Review of a facility incident report/investigation, dated 06/06/2025, showed that Resident 5 had a fall that resulted in skin tears (wounds).

<Resident 7>

Review of a facility incident report/investigation, dated 06/06/2025, showed that Resident 7 had a fall.

<Resident 9>

Review of a facility incident report/investigation, dated 06/07/2025, showed that Resident 9 had a fall and injured their head and shoulder.

<Resident 10>

Review of a facility incident report/investigation, dated 06/09/2025, showed that Resident 10 had a fall that resulted in skin tears.

<Resident 12>

Review of a facility incident report/investigation, dated 06/10/2025, showed that Resident 12 had a fall that resulted in bruises to their left arm.

In an interview on 06/13/2025 at 9:32 AM, Staff G, Regional Health and Wellness Specialist, stated they did not discuss resident falls during the Weekly at Risk Meeting unless a resident had two falls in the past month.

Review of the Weekly at Risk Report, dated 06/13/2025, showed no falls listed for the six residents from 06/05/2025 to 06/10/2025.

This is an uncorrected deficiency previously cited on 04/15/2025.

Review of a facility incident report/investigation, dated 06/06/2025, showed that Resident 5 had a fall that resulted in skin tears (wounds).

<Resident 7>

Review of a facility incident report/investigation, dated 06/06/2025, showed that Resident 7 had a fall.

<Resident 9>

Review of a facility incident report/investigation, dated 06/07/2025, showed that Resident 9 had a fall and injured their head and shoulder.

<Resident 10>

Review of a facility incident report/investigation, dated 06/09/2025, showed that Resident 10 had a fall that resulted in skin tears.

<Resident 12>

Review of a facility incident report/investigation, dated 06/10/2025, showed that Resident 12 had a fall that resulted in bruises to their left arm.

In an interview on 06/13/2025 at 9:32 AM, Staff G, Regional Health and Wellness Specialist, stated they did not discuss resident falls during the Weekly at Risk Meeting unless a resident had two falls in the past month.

Review of the Weekly at Risk Report, dated 06/13/2025, showed no falls listed for the six residents from 06/05/2025 to 06/10/2025.

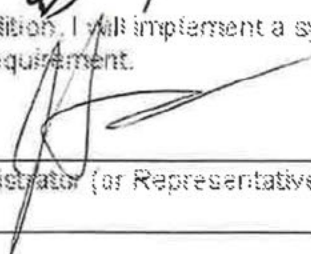
This is an uncorrected deficiency previously cited on 04/15/2025.

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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 Point Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 8/20/25 **9/14/2025**

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



Administrator (or Representative)

7/1/25

Date

WAC 388-73A-2120 Monitoring residents' well-being. The assisted living facility must:

- (1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;
- (2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:
 - (b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor the need for as needed medications for bowel movements for 1 of 7 residents (Resident 3). This failure placed the resident at risk of health complications.

Findings included...

<Resident 3>

Review of Resident 3's Negotiated Care Plan (the facility's filed negotiated Service agreement), dated 06/21/2025, showed that the resident had a diagnosis of [REDACTED] and had been observed to respond to questions by smiling and nodding their head even when they may not have understood the question. The care plan showed that the resident was not able to walk, used a wheelchair, and required staff assistance to use the restroom and after incontinence episodes (involuntary elimination of urine and bowel). Further review showed that the resident required assistance with medications from facility staff.

Review of Resident 3's June 2025 Medication Administration Record (MAR) showed an

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-2120 Monitoring residents' well-being. The assisted living facility must:

- (1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;
- (2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:
 - (b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor the need for as needed medications for bowel movements for 1 of 7 residents (Resident 3). This failure placed the resident at risk of health complications.

Findings included...

<Resident 3>

Review of Resident 3's Negotiated Care Plan (the facility's titled negotiated Service agreement), dated 05/21/2025, showed that the resident had a diagnosis of [REDACTED] and had been observed to respond to questions by smiling and nodding their head even when they may not have understood the question. The care plan showed that the resident was not able to walk, used a wheelchair, and required staff assistance to use the restroom and after incontinence episodes (involuntary elimination of urine and bowel). Further review showed that the resident required assistance with medications from facility staff.

Review of Resident 3's June 2025 Medication Administration Record (MAR) showed an

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order to give isoperamide (used to treat loose stool) every morning.

Review of Resident 3's June 2025 MAR showed an order to give senna laxative (used to treat constipation) two tablets as needed for no bowel movement (BM) after 48 hours.

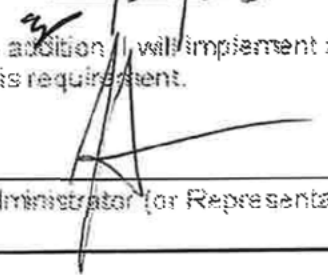
Review of Resident 3's June 2025 MAR showed an order to give polyethylene glycol (used to treat constipation) as needed for no BM in 24 hours after senna.

Review of Resident 3's undated medical chart showed no documentation of monitoring for bowel movements.

In an interview on 06/12/2025 9:20 AM, Staff G, Regional Health & Wellness Specialist, stated that facility staff had not been monitoring bowel function for Resident 3.

In an interview on 06/13/2025 at 2:25 PM, Resident 3 showed they did not have the cognitive functioning to determine if they had suffered from constipation or not and could not remember when or if they had a bowel movement recently.

This is an uncorrected deficiency previously cited on 04/15/2025, and a recurring deficiency previously cited on 12/05/2023 for subsection (1).

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 Point Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>8/30/25</u> 9/14/2025	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	 Date

WAC 385-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

order to give loperamide (used to treat loose stool) every morning.

Review of Resident 3's June 2025 MAR showed an order to give senna laxative (used to treat constipation) two tablets as needed for no bowel movement (BM) after 48 hours.

Review of Resident 3's June 2025 MAR showed an order to give polyethylene glycol (used to treat constipation) as needed for no BM in 24 hours after senna.

Review of Resident 3's undated medical chart showed no documentation of monitoring for bowel movements.

In an interview on 06/13/2025 9:20 AM, Staff G, Regional Health & Wellness Specialist, stated that facility staff had not been monitoring bowel function for Resident 3.

In an interview on 06/13/2025 at 2:25 PM, Resident 3 showed they did not have the cognitive functioning to determine if they had suffered from constipation or not and could not remember when or if they had a bowel movement recently.

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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-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

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(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

- (a) Nursing services supervision,
- (b) Nurse delegation, if provided,
- (c) Initial and on-going assessments of the nursing needs of each resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide safe intermittent nursing service practices for 3 of 3 residents (Resident 2, 13, and 15) sampled for nurse delegation. This failure resulted in the residents receiving delegated nursing tasks without the oversight of a registered nurse and placed the residents at risk of serious health complications.

Findings included...

Per WAC 246-840-930, Criteria for nurse delegation, before delegating a nursing task, the registered nurse delegator must:

- Assess the ability of the Nursing Assistant (NA) or Home Care Aid (HCA) to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.
- With delegation of insulin injections, the supervision occurs at least every two weeks for the first four weeks and may be more frequent.
- Checking blood sugars and administering insulin are nurse delegated tasks that require registered nurse supervision and oversight by trained staff.
- The registered nurse delegator ensures safe and effective services are provided. Re-evaluation and documentation occur at least every 90 days.

<Resident 2>

Review of Resident 2's Negotiated Care Plan (NCP, facility's negotiated service agreement), dated 12/23/2024, showed the resident was diagnosed with [REDACTED] and [REDACTED]. Further review showed that the resident required assistance with medications and diabetic management that included blood sugar checks (measurement of sugar in the blood).

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide safe intermittent nursing service practices for 3 of 3 residents (Resident 2, 13, and 15) sampled for nurse delegation. This failure resulted in the residents receiving delegated nursing tasks without the oversight of a registered nurse and placed the residents at risk of serious health complications.

Findings included...

Per WAC 246-840-930, Criteria for nurse delegation, before delegating a nursing task, the registered nurse delegator must:

- Assess the ability of the Nursing Assistant (NA) or Home Care Aid (HCA) to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.

-With delegation of insulin injections, the supervision occurs at least every two weeks for the first four weeks and may be more frequent.

-Checking blood sugars and administering insulin are nurse delegated tasks that require registered nurse supervision and oversight by trained staff.

- The registered nurse delegator ensures safe and effective services are provided. Re-evaluation and documentation occur at least every 90 days.

<Resident 2>

Review of Resident 2's Negotiated Care Plan (NCP, facility's negotiated service agreement), dated 12/23/2024, showed the resident was diagnosed with [REDACTED] and [REDACTED]. Further review showed that the resident required assistance with medications and diabetic management that included blood sugar checks (measurement of sugar in the blood)

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and insulin administration by trained staff.

Review of Resident 2's June 2025 Medication Administration Record (MAR) showed an order to obtain the resident's blood glucose (blood sugar) prior to meals and at bedtime. The MAR showed the resident received long-acting insulin by injection every evening.

Review of Resident 2's Nurse Delegation Visit form, dated 06/13/2025, showed that the resident required nurse delegation for blood glucose monitoring and for insulin administration.

Review of Resident 2's records showed no documentation of a nurse delegation reevaluation that was required to be completed by 06/13/2025.

<Resident 13>

Review of the facility's Resident Characteristic Roster, dated 06/12/2025, showed that Resident 13 was admitted to the facility on [REDACTED] 2022 and required nurse delegation.

Review of Resident 13's June 2025 MAR showed an order stating, "May crush medications," starting 06/04/2025.

In an interview on 06/13/2025 at 1:39 PM, Staff H, Medication Aide, stated that they had been crushing medications "just recently" and had received no instruction from the RND regarding crushing Resident 13's medications.

Review of the facility's nurse delegation records showed no documentation of a RND assessment of staff to safely crush medications (nurse delegated task).

<Resident 15>

Review of the facility's Resident Characteristic Roster, dated 06/12/2025, showed that Resident 15 was admitted to the facility on [REDACTED] 2025, was on insulin, and required nurse delegation.

Review of Resident 15's NCP, dated 06/13/2025, showed that the resident had diagnoses of [REDACTED]

Review of Resident 15's Nurse Delegation Visit form, dated 06/30/2025, showed that the resident required nurse delegation for blood glucose monitoring and for insulin

and insulin administration by trained staff.

Review of Resident 2's June 2025 Medication Administration Record (MAR) showed an order to obtain the resident's blood glucose (blood sugar) prior to meals and at bedtime. The MAR showed the resident received long-acting insulin by injection every evening.

Review of Resident 2's Nurse Delegation Visit form, dated 03/13/2025, showed that the resident required nurse delegation for blood glucose monitoring and for insulin administration.

Review of Resident 2's records showed no documentation of a nurse delegation reevaluation that was required to be completed by 06/13/2025.

<Resident 13>

Review of the facility's Resident Characteristic Roster, dated 06/12/2025, showed that Resident 13 was admitted to the facility on [REDACTED]/2022 and required nurse delegation.

Review of Resident 13's June 2025 MAR showed an order stating, "May crush medications," starting 06/04/2025.

In an interview on 06/13/2025 at 1:39 PM, Staff H, Medication Aide, stated that they had been crushing medications "just recently" and had received no instruction from the RND regarding crushing Resident 13's medications.

Review of the facility's nurse delegation records showed no documentation of a RND assessment of staff to safely crush medications (nurse delegated task).

<Resident 15>

Review of the facility's Resident Characteristic Roster, dated 06/12/2025, showed that Resident 15 was admitted to the facility on [REDACTED]/2025, was on insulin, and required nurse delegation.

Review of Resident 15's NCP, dated 06/13/2025, showed that the resident had diagnoses of [REDACTED]

Review of Resident 15's Nurse Delegation Visit form, dated 05/30/2025, showed that the resident required nurse delegation for blood glucose monitoring and for insulin

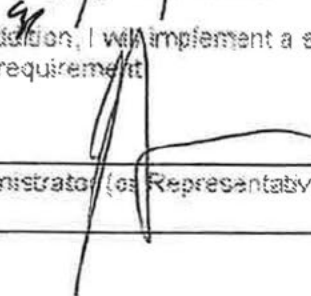
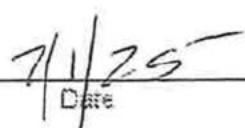
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administration.

Review of the facility's nurse delegation records showed no documentation of a RND visit that was required to occur by 06/13/2025.

Review of Resident 15's June 2025 MAR showed that the resident received blood sugar checks and long-acting insulin injections twice daily.

This is an uncorrected deficiency previously cited on 04/15/2025.

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 Point Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 8/30/25 9/14/2025	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement	
 Administrator (or Representative)	 Date

administration.

Review of the facility's nurse delegation records showed no documentation of a RND visit that was required to occur by 06/13/2025.

Review of Resident 15's June 2025 MAR showed that the resident received blood sugar checks and long-acting insulin injections twice daily.

This is an uncorrected deficiency previously cited on 04/15/2025.

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 Point Village, Assisted Living & Memory Care 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

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



Residential Care Services Investigation Summary Report

Provider/Facility: North Point Village, Assisted **Provider Type:** Assisted Living Facility
Living & Memory Care

License/Cert.#: 2479

Intake ID: 170137

Compliance Determination #: 56046

Region/Unit #: RCS Region 1 / Unit B

Investigator: Tethra Wales

Investigation Date(s): 03/11/2025 through 04/15/2025

Complainant Contact Date(s):

Allegation(s):

Infection Control

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 14 Closed records sample size: 0
Observations:	Staff Personal protection supplies Infection Control practices including handwashing and glove use
Interviews:	Staff Residents Administrator Health and Wellness Specialist
Record Reviews:	Resident face sheets, progress notes and MARs Respiratory protection program and infection control policies

Investigation Summary:

Sampled residents missed multiple doses of medications prescribed after being diagnosed with [REDACTED] and [REDACTED]. The facility misplaced the medication for two sampled residents resulting in missed doses and was unable to determine why the medication for a third resident was not administered. The assisted living facility failed to ensure that residents received medications as prescribed. Facility failed practice cited under WAC 388-78A-2210 (1)(a)(b)(2)(a)(b).

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 Point Village, Assisted **Provider Type:** Assisted Living Facility
Living & Memory Care

License/Cert.#: 2479

Intake ID: 170693

Compliance Determination #: 56046

Region/Unit #: RCS Region 1 / Unit B

Investigator: Tethra Wales

Investigation Date(s): 03/11/2025 through 04/15/2025

Complainant Contact Date(s):

Allegation(s):

Resident had a fall which resulted in multiple injuries.

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 14 Closed records sample size: 0
Observations:	Resident care equipment Resident rooms Staff to resident interactions Medication administration
Interviews:	Family members Nursing staff
Record Reviews:	Medical records Facility policies Incident investigation

Investigation Summary:

Resident had a fall and was transported to the hospital. Resident returned to the facility with a fractured humerus and a sprained ankle. That same evening the resident was sent out again for complaints of chest pain. Hospital admitted the resident and reported that they had a broken sternum and UTI. Resident was unable to be observed or interviewed due to being at the hospital. Sampled residents showed that several residents had multiple falls, that the facility did not investigate all of the falls, and that the facility's response was inconsistent with their fall policy. Facility failed practice cited under WAC 388-78A-2600 (1)(a)(b) and 388-78A-2371 (1)(2)(3).

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 Point Village, Assisted **Provider Type:** Assisted Living Facility
Living & Memory Care

License/Cert.#: 2479

Intake ID: 170938

Compliance Determination #: 56046

Region/Unit #: RCS Region 1 / Unit B

Investigator: Tethra Wales

Investigation Date(s): 03/11/2025 through 04/15/2025

Complainant Contact Date(s):

Allegation(s):

1. Residents not wearing identification bracelets
 2. Injuries from food and beverages being too hot
 3. Unorganized medication carts
 4. Pests/ants in building
 5. Caregivers not trained appropriately.
 6. Medication Technicians not certified or trained appropriately.
-

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 14 Closed records sample size: 0
Observations:	Residents Staff Resident care Staff to resident interactions Medication administration Food service Facility grounds tour interior and exterior Medication carts Kitchen inspection Food and beverage temperatures
Interviews:	Staff Residents Family members Administrator Health and Wellness Specialist Maintenance staff
Record Reviews:	Resident's facesheet Resident's progress notes Resident's MARs Facility policies Staff records Maintenance records

Investigation Summary:

1. Residents and staff were interviewed. Residents had no concerns about the staff not knowing their names. Facility policies were reviewed. No deficient practices found.
2. Residents and staff were interviewed. Residents did not have any complaints about the food or beverage temperatures. Staff checked water and food temperatures prior to passing food trays to residents in memory care and the department checked food and beverage temperatures and they were within regulation ranges. There were no recent incidents or injuries involving food temperatures. No deficient practices found.
3. Staff were interviewed and medication carts were inspected and were clean and organized. No deficient practice identified.
4. A thorough inspection of interior and exterior grounds completed with no evidence of ants or pest control concerns were found. Staff and residents denied any concerns with ants/mice or other pests. Maintenance staff had monthly pest control procedures and an outside company that also attended to any pest concerns. No deficient practices found.
5. Staff sample record review showed some staff were missing certifications. This deficient practice was cited for WAC 388-78a-2474 (2)(a)(b)(c)(d).
6. Medication technician staff sample showed one medication tech was missing CPR training. This deficient practice was cited for WAC 388-78a-2474 (2)(d).

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 Point Village, Assisted **Provider Type:** Assisted Living Facility
Living & Memory Care

License/Cert.#: 2479

Intake ID: 171269

Compliance Determination #: 56046

Region/Unit #: RCS Region 1 / Unit B

Investigator: Tethra Wales

Investigation Date(s): 03/11/2025 through 04/15/2025

Complainant Contact Date(s):

Allegation(s):

Resident fall with injury

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 14 Closed records sample size: 0
Observations:	Residents Staff Resident care equipment Resident rooms Staff to resident interactions
Interviews:	Staff Residents Administrator Health and Wellness Specialist Resident Representatives Sample Residents and Representatives Caregivers
Record Reviews:	Resident facesheet Resident's NSA Resident's assessments Resident's progress notes Resident's MARs Resident's Medical records Facility policies Incident investigation

Investigation Summary:

Resident had a fall with bruising and abrasions to their face and was transported to the hospital. Resident's records and investigations were reviewed. Facility's policy was reviewed. Resident and their representatives were interviewed. Staff and administration were interviewed. The facility had a policy for residents who had

more than two falls in a 30 day period and that these residents would be discussed at a weekly at risk meeting, The facility did not follow this policy. This failed practice was cited under WAC 388-78A-2600 (1)(a)(b).

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
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2479	Compliance Determination # 56046
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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 the unannounced on-site full inspection and complaint investigation on 03/11/2025, 03/12/2025, 03/13/2025, 03/14/2025, 03/18/2025, 03/27/2025 and 03/19/2025 of:
 North Point Village, Assisted Living & Memory Care
 1110 E Westview Ct
 Spokane, WA 99218

This document references the following complaint numbers: 170137, 170693, 170938, 171282, 171269.

The following sample was selected for review during the unannounced on-site visit: 14 of 84 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Veronica Jackson, Assisted Living Facility Licensors
 Jennifer Lee, Assisted Living Facility Licensors
 Joy Pipgras, LTC Surveyor
 Tethra Wales, Assisted Living Facility Licensors

From:
 DSHS, Aging and Long-Term Support Administration
 Residential Care Services, Region 1, Unit B
 8517 E Trent Ave, Ste 102
 Spokane Valley, WA 99212

Statement of Deficiencies

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04/15/2025

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.

J. Salquist
Residential Care Services

04/28/2025

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)

4.30.25

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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a safe medication system was in place and medications were given as prescribed to 5 of 12 residents (Resident 1, 2, 8, 11, and 12). This failure resulted in medications not given as prescribed for Residents 8, 11, and 12 and physician's orders not being followed for Resident 1 and 2.

Findings included...

Resident 1

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

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Review of Resident 1's Negotiated Service Plan (NSP, the facility's titled negotiated service agreement), dated 07/08/2024, showed that Resident 1 required facility staff medication assistance and that the licensed nurse or medication technician med tech would be responsible for assisting the resident with their medications. Further review showed that Resident 1 had a diagnosis of [REDACTED].

Review of Resident 1's December 2024, January 2025, February 2025, and March 2025 Medication Administration Records (MARS) showed an order for metoprolol succinate (used to treat high blood pressure) to be given twice daily, that included directives for the medication technician to notify the nurse when the resident's SBP (systolic blood pressure / top number) was greater than 140 or less than 110 and DBP (diastolic blood pressure / bottom number) was greater than 90 or less than 60. Further review showed that Resident 1's blood pressure was outside the designated parameters 73 times on the following dates:

SBP greater than 140: 12/07/2024 (159), 12/08/2024 (162), 12/11/2024 (151), 12/15/2024 (141), 12/18/2024 (158), 12/20/2024 (143), 12/25/2024 (150), 12/28/2024 (156), 12/29/2024 (146), 12/30/2024 (151), 12/31/2024 (144), 01/01/2025 AM (160), 01/01/2025 PM (161), 01/02/2025 (161), 01/03/2025 (142), 01/04/2025 (164), 01/05/2025 AM (161), 01/05/2025 PM (151), 01/08/2025 AM (145), 01/08/2025 PM (141), 01/09/2025 AM (153), 01/09/2025 PM (156), 01/10/2025 (145), 01/11/2025 (143), 01/12/2025 (149), 01/13/2025 (155), 01/14/2025 AM (143), 01/14/2025 PM (145), 01/15/2025 (155), 01/16/2025 AM (163), 01/16/2025 PM (165), 01/19/2025 (147), 01/20/2025 (147), 01/22/2025 (149), 01/24/2025 (143), 01/28/2025 AM (151), 01/28/2025 PM (152), 01/29/2025 (154), 02/01/2025 AM (142), 02/01/2025 PM (142), 02/02/2025 (162), 02/03/2025 (166), 02/06/2025 (161), 02/07/2025 (146), 02/08/2025 (146), 02/09/2025 (159), 02/12/2025 (141), 02/13/2025 (162), 02/17/2025 AM (146), 02/17/2025 PM (158), 02/19/2025 (141), 02/20/2025 AM (145), 02/20/2025 PM (146), 02/22/2025 (152), 02/24/2025 (142), 02/25/2025 (142), 03/01/2025 (155), 03/03/2025 (146), 03/04/2025 (143), 03/08/2025 (149)

SBP less than 110: 12/12/2024 (105), 01/21/2025 (107)

DBP less than 60: 12/06/2024 (58), 12/13/2024 (52), 01/04/2025 (59), 01/06/2025 (53), 01/20/2025 (56), 01/26/2025 (56), 01/30/2025 (59), 02/08/2025 (58), 02/27/2025 (55), 03/05/2025 (59), 03/06/2025 (52)

Review of Resident 1's December 2024, January 2025, February 2025, and March 2025 Progress Notes showed no documentation related to Resident 1's blood pressure or any communication with nurse to advise the resident's measurements were outside of parameters.

In an interview on 03/12/2025 at 2:47 PM, Staff G, Health & Wellness Specialist, stated that when a resident was outside the parameters, staff were supposed to call them

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(Staff G) and document the call in the progress notes.

In an interview on 03/14/2025 at 10:30 AM, Staff G stated that they had not received any communication from staff regarding Resident 1's blood pressure when outside of the parameters. Staff G further stated that the instructions to contact the nurse if the resident's blood pressure was outside the parameters were included on the MARs due to Resident 1's unstable blood pressures.

Resident 2

Review of Resident 2's NSP, dated 12/23/2024, showed that Resident 2 required facility staff assistance with diabetic (high blood sugar) management and blood sugar checks.

In an interview on 03/19/2025 at 9:00 AM, Resident 2 stated that the staff assist with their blood sugar checks.

Review of Resident 2's January 2025, February 2025, and March 2025 MARs showed an order to check blood sugars before meals and bedtime and notify the nurse if blood sugars were below 100 or over 300. Further review showed no documentation related to Resident 2's blood sugar checks on the following dates:

01/12/2025 at 7:30 AM, 01/23/2025 at 07:30 PM, 01/24/2025 at 07:30 AM, 01/28/2025 at 4:30 PM, 01/28/2025 at 7:30 PM, 02/10/2025 at 11:30 AM, 02/13/2025 at 7:30 PM, and 03/01/2025 at 7:30 AM.

In an interview on 03/19/2025 at 2:55 PM, Staff G stated that they could not get verification why the blood sugars were not completed for the dates listed above because the blood sugars were done by agency staff, and they did not know which agency employee it was.

Resident 8

-Oseltamivir

Review of Resident 8's Negotiated Services Plan, dated 02/07/2025, showed that Resident 8 required facility staff medication assistance and that the resident would receive medications as ordered.

Review of Resident 8's March 2025, Progress Notes showed that on 03/07/2025 the

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resident was noted as "having the flu [influenza, a contagious respiratory infection]."

Review of Resident 8's March 2025 MAR, showed a health care provider order, dated 03/06/2025, for oseltamivir (medication used to treat influenza) to be given twice daily for five days. Further review showed that the medication was not administered on 03/07/2025 (both doses), 03/09/2025 (PM dose), and 03/10/2025 (PM dose).

In an interview on 03/12/2025 at 2:47 PM, Staff G stated that a day or two after the order was received, Staff M, Memory Care Director, stated they were unable to locate the medication. Staff G stated that they contacted the pharmacy and confirmed that the medication had been delivered. Staff G stated that the medication was located by a medication technician on 03/08/2024, in a closet in a separate building. Staff G further stated that they discontinued the medication on 03/12/2025 despite the resident not receiving the medication on the first day and that the medication was only administered for four out of the five-day duration it was ordered for.

-Guaifenesin

Review of Resident 8's December 2024 MAR showed an order for guaifenesin (used to treat coughs and congestion) to be given twice daily. Further review showed that the medication was not available on 12/24/2024 (PM dose) and 12/25/2024 (PM dose) was documented as 'refused' on 12/25/2024 (AM dose) and 12/26/2024 (AM dose).

In an interview on 03/14/2025 at 10:30 AM, Staff G stated that the guaifenesin had not been refused on the dates noted above and identified the chartings (documentation in resident record) as documentation errors. Staff G stated the medication had not been given on those dates.

-Trazodone

Review of Resident 8's health assessment, dated 02/07/2025, showed that Resident 8 had an altered sleep cycle and took a sleep aid medication. Further review showed that the resident had stated they had difficulty sleeping and falling asleep.

Review of Resident 8's December 2024 and January 2025 MARs showed a health care provider order for trazodone (a sleep aid) to be given one time daily at bedtime.

Further review showed that the trazodone was not given on 12/24/2024 through 01/02/2025, and on 01/06/2025, 01/07/2025, 01/11/2025, 01/12/2025, 01/14/2025, 01/15/2025, and 01/16/2025 (missed 17 doses).

In an interview on 03/14/2025 at 10:30 AM, Staff G stated that the trazodone had not

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been administered on the dates noted above and identified the chartings as documentation errors. Staff G stated the trazadone had not been given from 12/24/2024 through 01/16/2025.

-Acetaminophen

Review of Resident 8's health assessment, dated 02/07/2025, showed that Resident 8 experienced chronic (ongoing) pain.

Review of Resident 8's January 2025 MAR showed a health care provider order for acetaminophen (pain medication) to be given three times daily. Further review showed that on 01/16/2025 and 01/17/2025 the 8:00 AM and 2:00 PM doses were documented as administered, and that the 7:00 PM dose on both days was documented as not available.

In an interview on 03/14/2025 at 10:30 AM, Staff G identified the chartings as documentation errors and missed doses. Staff G further stated that the acetaminophen had been available to administer when it was documented as not available.

-Triamcinolone

Review of Resident 8's January 2025 MAR showed a health care provider order for triamcinolone (medicated rash cream) twice daily for 10 days. Further review showed that the evening dose was not administered on 01/21/2025 and 01/24/2025, with notes that indicated that on 1/21/2025 the medication technician was "unsure as to where medication is to be applied" and on 01/24/2025 they required "medication clarification."

In an interview on 03/12/2025 at 2:47 PM, Staff G stated that they were unaware that the medication technician did not know where to apply the medication and that they had not been notified of the missed medication applications.

Resident 11

Review of Resident 11's Face Sheet showed that the resident was admitted on [REDACTED]/2024 with a diagnosis of [REDACTED].

Review of Resident 11's NSP, dated 02/20/2025, showed that the resident needed facility staff assistance with all medications.

Review of Resident 11's Progress Notes, dated 03/03/2025, showed that the resident

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was sent to the hospital due to a fall. The notes showed that Resident 11 returned that evening with a diagnosis of [REDACTED] and [REDACTED], with a prescription for azithromycin (an antibiotic medication).

Review of Resident 11's March 2025 MAR showed that the resident was to receive azithromycin for five days. Further review showed "missed dose" on 03/07/2025, and there was no documentation as to why the medication had not been administered.

In an interview on 03/14/2025 at 10:48 AM, Staff G stated they did not know why the medication had not been administered.

In an interview on 03/14/2025 at 10:30 AM, Staff G stated that audits of the MARS and medication carts were done "inconsistently."

Resident 12

Review of Resident 12's NSP, dated 03/08/2025, showed diagnoses of [REDACTED] and [REDACTED]. Further review showed that Resident 12 required facility staff medication assistance and a licensed nurse or medication technician would be responsible for assisting the resident with their medications.

Review of Resident 12's March 2025 Progress Notes showed that the resident was sent out to the hospital on 03/01/2025 due to vomiting. Further review showed an entry dated 03/05/2025, that indicated that the resident was hospitalized for acute respiratory failure with hypoxia (lack of oxygen supply), pneumonia (an infection of the lungs) and influenza.

Review of Resident 12's March 2025 MAR showed a health care provider order, dated 03/05/2025, for oseltamivir to be given twice daily for five days. Further review showed the following:

03/06/2025 AM Medication not available
 03/06/2025 PM Administered
 03/07/2025 AM Administered
 03/07/2025 PM Medication hasn't arrived at the cottages yet
 03/08/2025 AM Medication not available
 03/08/2025 PM "Exp"
 03/09/2025 AM Not administered, no additional notes
 03/09/2025 PM Not administered, no additional notes
 03/10/2025 AM Not administered, no additional notes
 03/10/2025 PM Not administered, no additional notes

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In an interview on 03/14/2025 at 10:30 AM, Staff G stated that Resident 8's oseltamivir was found on 03/08/2025, outside of and behind a medication tote in a closet in a separate building. Staff G further stated that the entries on 03/06/2025 and 03/07/2025 where the medication was noted as 'administered,' were documentation errors and that the medication had not yet been located. Staff G confirmed that the oseltamivir was discontinued by the facility (in error) after three days and was not given on two of the five-day duration it was ordered for. Staff G further stated that it was possible that Resident 12 did not receive any doses of the oseltamivir.

This is a recurring deficiency previously cited on 10/04/2024 for subsection (2) (a), 08/27/2024 for subsection (1) (b), 06/24/2024 for subsection (2) (a), and 09/06/2023 for subsections (2)(a).

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 Point Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>5.30.25</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 _____ Administrator (or Representative)	<u>5.1.25</u> _____ Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

- (1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;
- (2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and
- (3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that negotiated service agreements were signed by the resident or the resident's representative, a facility representative, or the case manager for 4 of 13 residents (Resident 1, 3, 5, and 7). This failure placed residents at risk of unmet care needs and receiving services that were not agreed upon.

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Findings included...

Review of Resident 1's Negotiated Service Plan (NSP, the facility's titled negotiated service agreement), dated 07/08/2024, showed that the agreement did not contain the required signatures from the resident, the resident's representative, the facility's representative, or the case manager for the resident.

Review of Resident 3's NSP, dated 12/30/2024, showed that the agreement did not contain the required signatures from the resident, the resident's representative, or the facility's representative.

Review of Resident 5's NSP, dated 12/18/2025, showed that the agreement did not contain the required signatures from the resident, the resident's representative, or the facility's representative.

Review of Resident 7's NSP, dated 02/16/2025, showed that the agreement did not contain the required signatures from the resident, the resident's representative, or the facility's representative.

In an interview on 03/12/2025 at 10:15 AM Staff G, Health and Wellness Specialist, stated that Resident 5's NSP was not signed by the resident or their representative.

In an interview on 03/12/2025 at 2:47 PM, Staff G stated that they had arranged to have Resident 1 sign their NSP on 03/11/2025 (eight months after the NSP was written) but the facility staff was not available to meet with the resident.

In an interview on 03/18/2025 at 3:15 PM, Staff G stated that the NSPs for Resident 3 and Resident 7 were not signed by the resident or their representative.

This is a recurring deficiency previously cited on 12/05/2023 for subsections (1)(2).

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Administrator (or Representative)

5.1.25
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;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to investigate, document investigative findings, and determine circumstances of incidents for residents who had falls for 3 of 5 residents (Resident 7, 9, and 11). These failures placed the residents at risk for injury and recurring falls.

<Resident 7>

Review of Resident 7's face sheet showed an admission date of [REDACTED]/2023. The face sheet showed that the resident was diagnosed with [REDACTED]

Observation on 03/14/2025 at 12:00PM, showed Resident 7 sat in a wheelchair and had bruising over their entire face with abrasions on their forehead and side of their nose.

Review of Resident 7's Progress Notes showed that the resident had falls on 01/16/2025, 02/08/2025, 02/27/2025, 03/01/2025, and 03/11/2025. Review of the notes showed no documented investigations of the falls. Further review showed no documentation of the circumstances leading to the falls.

<Resident 9>

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Review of Resident 9's face sheet showed an admission date of [REDACTED]/2016. The face sheet showed that the resident was diagnosed with [REDACTED].

Review of Resident 9's Progress Notes showed that the resident had falls on 01/15/2025 and 01/21/2025. Review of the notes showed no documented investigations of the falls. Further review showed no documentation of the circumstances leading to the falls.

In an interview on 03/13/2025 at 1:50 PM, Collateral Contact 2, Resident 9's Representative, stated that Resident 9 fell often in the evening and night, and that they were concerned about the resident's falls.

In an interview on 03/18/2025 at 10:45 AM, Staff G, Health and Wellness Specialist, stated that they could not find any investigations for Resident 9's falls that occurred on 01/15/2025 and 01/21/2025.

<Resident 11>

Review of Resident 11's face sheet showed an admission date of [REDACTED]/2024. The face sheet showed that the resident was diagnosed with [REDACTED].

Review of Resident 11's Progress Notes showed that the resident had unwitnessed falls on 02/22/2025, 02/27/2025, 03/03/2025, and 03/05/2025. Review of the notes showed no documented investigations for the falls. Further review showed no documentation of the circumstances leading to the falls.

In an interview on 03/19/2025 at 9:39 AM, Staff G stated they gave the department all the investigations they had completed for Resident 11.

Review of Resident 11's records as of 03/19/2025, showed no documentation of investigations for falls for 02/22/2025, 02/27/2025, 03/03/2025, and 03/05/2025.

This is a recurring deficiency previously cited on 10/04/2024, 06/21/2024, and 12/28/22 for subsections (1) (2).

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Administrator (or Representative)

5.1.25
Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

- (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
 - (c) Known allergies to foods or medications, or other considerations for providing care or services.
- (2) Currently necessary and contraindicated medications and treatments for the individual, including:
 - (a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;
 - (b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and
 - (c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.
- (3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.
- (4) Individual's sensory abilities, including:
 - (a) Vision; and
 - (b) Hearing.

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(5) Individual's communication abilities, including:

- (a) Modes of expression;
- (b) Ability to make self understood; and
- (c) Ability to understand others.

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

- (a) History of substance abuse;
- (b) History of harming self, others, or property; or
- (c) Other conditions that may require behavioral intervention strategies;
- (d) Individual's ability to leave the assisted living facility unsupervised; and
- (e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

(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:

- (a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;
- (b) Developmental disability;
- (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;
- (b) Medication management ability, including:
 - (i) The individual's ability to obtain and appropriately use over-the-counter medications; and
 - (ii) How the individual will obtain prescribed medications for use in the assisted living facility.

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including

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preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a full assessment within 14 days of admission for 2 of 2 residents (Resident 4 and 11). This failure placed the residents at risk of not receiving care that supported or aligned with their current needs.

Findings included...

<Resident 4>

Review of Resident 4's face sheet showed the resident admitted to the facility on [REDACTED]/2025. Further review of the resident's records showed it did not contain a full 14-day assessment.

In an interview on 03/12/2025 at 4:23 PM, Staff G, Health and Wellness Specialist, stated they did not have a 14-day assessment for Resident 4.

<Resident 11>

Review of Resident 11's face sheet showed the resident admitted to the facility on [REDACTED]/2024. Further review of the resident's records showed it did not contain a full 14-day assessment.

In an interview on 03/12/2025 at 4:23 PM, Staff G stated they did not have a 14-day assessment for Resident 11.

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


Administrator (or Representative)

5.1.25
Date

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(5) The release of audio or video monitoring recordings by the facility is prohibited. Each person or organization with access to the electronic monitoring must be identified in the resident's negotiated service agreement.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

(11) If a resident's decision maker consents to audio electronic monitoring as specified in (10) above, the assisted living facility must maintain a copy of the court order authorizing such consent in the resident's record.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to reevaluate the need for electronic monitoring, obtain dated signatures from residents, and document in negotiated service agreements, each person who had access to the monitoring for 2 of 2 residents (Resident 7 and 13) and failed to obtain a court order for audio monitoring for 1 of 2 residents (Resident 13). These failures resulted in the unauthorized audio monitoring of Resident 13 and placed the residents in the memory care unit at risk of being videotaped and audio monitored without consent.

Findings included...

Review of the facility's undated policy titled, "Washington Electronic Monitoring Requirements," showed that if a resident requested video and/or audio monitoring, the assisted living facility will have agreed upon a specific duration for the electronic monitoring; and the monitoring would be documented in writing and reevaluated at least quarterly. Further review showed that the assisted living facility would maintain a

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copy of a court order authorizing audio electronic monitoring.

In an interview on 03/14/2025 at 10:30 AM, Staff G, Health and Wellness Specialist, stated that there were two residents that had a video camera in their rooms. Staff G further stated that they had not obtained any written consents with signatures or had completed any quarterly reviews.

<Resident 7>

Observation on 03/14/2025 at 12:00PM showed Resident 7's camera to be on top of the resident's dresser facing the bed.

Review of Resident 7's Negotiated Service Plan (NSP, the facility's titled negotiated service agreement), dated 02/16/2025, showed there was a camera (electronic monitoring) in the resident's room but did not document who had access to the footage, when the camera was placed, or an evaluation of the need for electronic monitoring.

<Resident 13>

Observation on 03/14/2025 at 11:35 AM showed signage of electronic monitoring on Resident 13's door. Further observation showed that the camera was located on top of the resident's closet facing their bed and the hallway.

Review of Resident 13's NSP, dated 02/13/2025, showed there was a camera in the resident's room but did not document who had access to the footage, when the camera was placed, or an evaluation of the need for electronic monitoring.

In an interview on 03/14/2025 at 11:45 AM, Collateral Contact (CC1), Resident Representative, stated that they had never signed a consent for electronic monitoring, and that the camera had been placed in the resident's room "a couple years ago". CC1 also stated that the camera had audio capabilities and that they and a sibling, did see, hear, and talk to the resident through the system. CCI stated, "We can see [Resident 13's] bed and people that pass by in the hallway".

In an interview on 03/14/2025 at 3:30 PM, Staff G stated they were not aware that the facility was required to gain written consent for any electronic monitoring, and that the facility was to have obtained a copy of a court order specifically authorizing the consent to audio electronic monitoring. Staff G also stated they were not aware that the camera could view and hear other residents in the hallway.

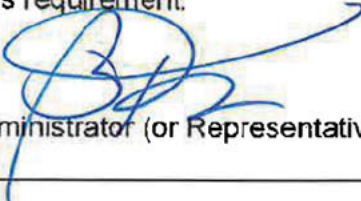
Review of Resident 13's undated medical records showed no court order for audio monitoring.

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5.1.25
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:

- (a) Maintain or enhance the quality of life for residents including resident decision-making rights;
- (b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to follow their policies and procedures related to falls for 4 of 5 residents (Residents 4, 7, 9, and 11). This failure resulted in resident falls not being tracked and in a lack of interventions to prevent falls, and placed residents at risk for harm.

Findings included...

Review of the facility's undated policy titled, "Fall Management and Recovery," showed that the community would implement interventions after a resident fall to reduce the risk of future falls and injury, and that residents who had experienced two or more falls in the previous 30 days would be added to a Weekly At Risk Report. Further review showed that the facility would track resident falls monthly with the goal of reducing falls.

<Resident 4>

Review of Resident 4's Progress Notes showed that the resident had nine falls since their admission date of [REDACTED]/2025. Further review showed that on 02/01/2025 the

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resident fell and broke a rib, their sternum and sprained an ankle, and on 03/03/2025 Resident 4 had a fall and hit their head.

In an interview on 03/14/2025 at 2:20PM, Staff G, Health and Wellness Specialist, stated there were no Weekly at Risk Reports to review for Resident 4 to track falls and potential fall interventions.

<Resident 7>

Review of Resident 7's Progress Notes showed that the resident had 11 falls between 12/18/2024 to 03/11/2025. Further review showed that falls on 03/10/2025 and 03/11/2025 resulted in injuries to the head.

In an interview on 03/14/2025 at 2:20PM, Staff G stated there were no Weekly at Risk Reports to review for Resident 7 to track falls and potential fall interventions.

<Resident 9>

Review of Resident 9's January 2025 and February 2025 Progress Notes showed that the resident had five falls between 01/15/2025 and 02/12/2025

In an interview on 03/13/2025 at 1:50 PM, Collateral Contact 2, Resident Representative, stated that Resident 9 fell often in the evening and night, and that they were concerned about these falls.

In an interview on 03/14/2025 at 2:20PM, Staff G stated there were no Weekly at Risk Reports to review for Resident 9 to track falls and potential fall interventions.

<Resident 11>

Review of Resident 11's Progress Notes showed that the resident had three falls on 02/22/2025, 02/27/2025, and 03/03/2025. Further review showed that the fall on 03/03/2025 resulted in an injury to the head.

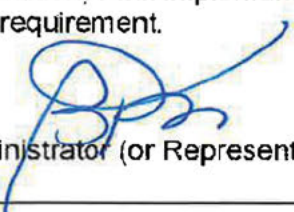
In an interview on 03/14/2025 at 2:20PM, Staff G, stated there were no Weekly at Risk Reports to review for Resident 11 to track falls and potential fall interventions. Staff G further stated that they had not held Weekly At Risk Meetings, created a Weekly At Risk Report, or tracked facility falls the past few months as required per the facility policy.

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Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;
- (2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:
 - (b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor for changing physical health conditions for 1 of 9 residents (Resident 3). These failures placed the residents at risk for health complications.

Findings included...

Resident 3

Review of Resident 3's functional, assessment dated 11/03/2024, showed diagnoses of [REDACTED] and [REDACTED]. Further review showed Resident 3 required regular prompting due to confusion and disorientation.

Review of Resident 3's January 2025, February 2025, and March 2025 MARs showed an order for loperamide (used to treat diarrhea) to give each day in the morning and to increase dose if necessary. Further review showed another order to give loperamide every 6 hours as needed (to indicate if not effective) for diarrhea.

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Review of Resident 3's MARs dated January 2025, February 2025 and March 2025 showed an order to give Senna laxative (used to treat constipation) two tablets as needed for no bowel movement (BM) after 48 hours.

Review of Resident 3's MARs dated January 2025, February 2025 and March 2025 showed an order to give polyethylene glycol (used to treat constipation) dissolved in juice as needed for no BM in 24 hours after receiving the senna.

In an interview on 03/13/2025 at 2:25 PM, Resident 3 was unable to recall their bowel history due to cognitive impairment.

In an interview on 03/14/2025 at 9:00 AM, Staff I, Medication Aide, stated that care staff did not document when Resident 3 had BM's and was not sure if care staff would know if the resident had constipation.

Review of Resident 3's undated medical chart showed no documentation of monitoring for bowel movements to determine if as needed medications were necessary.

In an interview on 03/14/2025 at 10:35 AM, Staff G, stated that Resident 3 or their spouse would likely not have the cognitive ability to state when Resident 3 had a BM last and confirmed staff do not monitor or track BMs for the resident (for the purpose of determining if the resident needed an as need medication).

This is a recurring deficiency previously cited on 12/05/2023 for subsections (1)(3)(a)(4) and 01/04/2023 for subsections (3)(a)(4).

Plan/Attestation Statement

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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;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete an annual self-medication assessment for 1 of 1 resident (Resident 1) sampled for medication self-administration. This failure resulted in Resident 1 not being assessed to ensure they had the cognitive abilities to safely administer their own medication and placed the resident at risk for medication errors.

Findings included...

Per WAC 388-78A-2090, the facility must assess residents for safety considerations that may pose a danger to the individual.

Review of the facility's policy titled, "Resident Self-Management of Medication," dated 08/26/2021, showed that the facility would allow a resident to administer their own medications if there was a physician's order and confirmation of competency through a self-medication evaluation conducted by the health and wellness director or designee.

Review of Resident 1's Negotiated Service Plan (NSP, the facility's titled negotiated service agreement), dated 07/08/2024, showed that Resident 1 had a diagnosis of [REDACTED]

Review of Resident 1's health assessment, dated 12/24/2024, showed that Resident 1 received medication assistance from facility staff.

Review of Resident 1's December 2024, January 2025, February 2025, and March 2025 Medication Administration Records (MARs) showed an order for Emgality pen (used for migraine prevention) to be injected one time per month.

Observation on 03/14/2025 at 10:00 AM showed three boxes of Emgality pens located in Resident 1's refrigerator in their apartment.

In an interview on 03/14/2025 at 10:00 AM, Resident 1 stated that they gave themselves the injections once a month. Resident 1 further stated that they handled the re-ordering and storage of the medication.

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In an interview on 03/14/2025 at 10:30 AM, Staff G, Health and Wellness Specialist, stated that they did not have a self-medication assessment for Resident 1's injections.

This is a recurring deficiency previously cited on 12/05/2023.

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	<u>5.1.25</u>
Administrator (or Representative)	Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

- (a) Orientation and safety;
- (b) Basic;
- (c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;
- (d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure orientation and safety training was completed by 1 of 5 staff (Staff D), failed to ensure basic training and professional certification was completed and obtained by 2 of 5 staff (Staff C and D), failed to ensure specialty training for mental health was completed by 1 of 5 staff (Staff D), and failed to ensure cardiopulmonary resuscitation and first aid training was obtained by 3 of 5 staff (Staff B, C and D). These failures placed residents at risk of receiving care from unqualified facility staff.

Findings included...

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Staff B

Review of Staff B's, Assisted Living Medication Aide, undated personnel record showed a hire date of 04/09/2024. Further review showed no documentation of cardiopulmonary resuscitation (CPR) and first aid training (required within 30 days of hire).

Staff C

Review of Staff C's, Memory Care Partner, undated personnel record showed a hire date of 03/20/2024. Further review showed no documentation of basic training (required to be completed within 120 days of hire date), certification of home health or nursing assistant (required within 200 days of hire date), or CPR and first aid training.

Staff D

Review of Staff D's, Assisted Living Care Partner, undated personnel records showed a hire date of 08/07/2024. Further review showed no documentation of orientation and safety, mental health specialty training, basic training, certification of home health or nursing assistant, or CPR and first aid training.

In an interview on 03/19/2025 at 9:40 AM, Staff A, Executive Director, stated they were unable to locate Staff B's CPR and first aid training, Staff C's basic training, professional credential, and CPR training, or Staff D's basic training, profession credential, safety and orientation training, mental health specialty training, and CPR training.

This is a recurring deficiency previously cited on 12/23/2024 for subsections (2)(a)(b)(c) and 12/05/2023 for subsections (2)(a).

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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 Point Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 5-30-25.

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


Administrator (or Representative)

5-1-25
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure consent was obtained for nurse delegation of insulin administration, failed to ensure an assessment of the resident's appropriateness for nurse delegation and the caregiver's ability to safely perform nurse delegation were completed, and failed to ensure supervision of the caregivers occurred within the required timeframe for 1 of 1 residents (Resident 2) sampled for nurse delegation. These failures resulted in the resident receiving delegated nursing tasks without the oversight of a registered nurse and placed the resident at risk for injury and health complications.

Findings included...

Per WAC 246-840-930, Criteria for nurse delegation, before delegating a nursing task, the registered nurse delegator must:

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- Obtain written consent from the resident or authorized representative for nurse delegation within 30 days.
- Assess the ability of the nursing assistant (NA) or home care aid (HCA) to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.
- With delegation of insulin injections, the supervision occurs at least every two weeks for the first four weeks, and may be more frequent.
- The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days.

Review of Resident 2's Negotiated Service Plan (the facility's titled negotiated service agreement), dated 12/23/2024, showed that Resident 2 received medication assistance from the facility staff. Further review showed that Resident 2 had a diagnosis of [REDACTED].

Review of Resident 2's December 2024 and January 2025 Medication Administration Records showed an order on 12/30/2024 for Lantus (medication used to lower blood sugar) to be given once daily by injection. Further review showed that staff administered the Lantus to Resident 2 beginning on 12/30/2024.

Review of Resident 2's Nurse Delegation Nursing Visit showed the initial assessment and caregiver list for Resident 2's Lantus pen injection occurred on 02/24/2025, 80 days after the medication was administered by facility staff for the first time.

Review of Resident 2's Nurse Delegation Consent showed the consent was also initially signed and dated on 02/24/2025.

In an interview on 03/18/2025 at 10:45 AM, Staff G, Health & Wellness Specialist, stated that Resident 2 was prescribed Lantus on 12/30/2024 due to high blood sugars.

Review of Resident 2's Nurse Delegation Instructions for Nursing Tasks dated 02/24/2025 showed instructions for the Lantus pen injection.

In an interview on 03/19/2025 at 9:10 AM, Resident 2 stated that they received injections for the Lantus by facility staff in the evenings.

In an interview on 03/18/2025 at 3:00 PM, Staff H, Assisted Living Medication Aide, stated that they administered Lantus to Resident 2 in the evenings.

In an interview on 03/18/2025 at 3:15 PM, Staff G stated Resident 2 started on Lantus injections on 12/30/2024. Staff G further stated the first visit for Resident 2's Lantus nurse delegation was on 02/24/2025.

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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 Point Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 5.30.25.

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


Administrator (or Representative)

5.1.25
Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that tuberculosis screening was completed within three days of hire for 3 of 6 staff (Staff B, C, and D). This failure placed residents at risk for exposure to tuberculosis infection.

Findings included...

<Staff B>

Review of the staff schedule for March 2025 showed that Staff B, Medication Aide, worked on 03/01/2025, 03/09/2025, 03/10/2025, and 03/11/2025.

Review of the undated personnel records for Staff B showed a hire date of 04/09/2024. Further review showed no documentation of tuberculosis (TB, a communicable respiratory disease) screening.

In an interview on 03/19/2025 at 9:39 AM, Staff A, Executive Director, stated that they were unable to locate documentation of TB screening for Staff B.

<Staff C>

Review of the staff schedule for March 2025 showed that Staff C, Care Partner, worked on 03/07/2025, 03/08/2025, 03/09/2025, and 03/10/2025.

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Review of the undated personnel records for Staff C showed a hire date of 03/20/2024. Further review showed no documentation of TB screening.

In an interview on 03/19/2025 at 9:39 AM, Staff A stated they were unable to locate documentation of TB screening for Staff C.

<Staff D>

Review of the staff schedule for March 2025 showed that Staff D, Care Partner, worked on 03/02/2025, 03/03/2025, 03/04/2025, 03/05/2025, 03/09/2025, 03/10/2025, and 03/11/2025.

Review of the undated personnel records for Staff D showed a hire date of 08/07/2024. Further review showed no documentation of TB screening.

In an interview on 03/19/2025 at 9:39 AM, Staff A stated they were unable to locate documentation of TB screening for Staff D.

This is a recurring deficiency previously cited on 12/23/2024.

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 Point Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 5.28.25

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


Administrator (or Representative)

5.1.25
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:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

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(i) The resident's preadmission assessment;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop a plan with interventions to monitor weight loss and nutritional deficiency, in the resident's negotiated service agreement, for 1 of 1 resident (Resident 4) with a history of weight loss and malnutrition. This failure placed the resident at risk of continued weight loss and health complications.

Findings included...

<Resident 4>

Review of Resident 4's pre-admission assessment, dated 01/08/2025, showed that the resident had an unplanned weight loss.

In an interview on 03/12/2025 at 3:30 PM, Resident 4 stated that they had recently lost 50 pounds prior to admission, was concerned with the loss, and would like to gain some weight.

Review of Resident 4's Negotiated Service Plan (NSP, the facility's titled negotiated service agreement), dated 03/09/2025, showed that the resident had a diagnosis of [REDACTED]. Further review showed that Resident 4 received a regular diet, did not have nutritional intake monitored, and did not receive dietary supplements.

Review of Resident 4's January 2025, February 2025 and March 2025 Medication and Treatment Administration Records showed no documentation of any weights.

In an interview on 03/18/2025 at 10:35 AM, Staff G stated that they did not have any weights since admission for Resident 4.

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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 Point Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 5.30.25

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


Administrator (or Representative)

5.1.25
Date



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

PSL Associates, LLC
North Point Village, Assisted Living & Memory Care
1110 E Westview Ct
Spokane, WA 99218

RE: North Point Village, Assisted Living & Memory Care # 2479

Dear Administrator:

This document references the following complaint numbers 170137, 170693, 170938, 171282, 171269.

The Department completed a full inspection and complaint investigation of your Assisted Living Facility on 04/15/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);
- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
 - o Sign and date the enclosed report;
 - o For each deficiency, indicate the date you have or will correct each deficiency;
 - o Return the Plan/Attestation Statement and report with signatures to:

Jessica Salquist, Regional Administrator

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

Residential Care Services

Region 1, Unit B

Preferred methods:

eFax: (509) 921-2426

Email: rcsregion1email@dshs.wa.gov

Optional method:

8517 E Trent Ave, Ste 102

Spokane Valley, WA 99212

- Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
- Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(d) Document and retain for twelve weeks, weekly staffing schedules, as planned and worked;

(h) Provide staff orientation and appropriate training for expected duties, including:

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

(v) Policies, procedures, and equipment necessary to perform duties;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW.

The facility was unable to locate the orientation checklist for one Medication Aide and unable to locate three weeks of staff schedules were not maintained of the staff's actual work schedules. This was discussed with the facility and will be corrected moving forward.

You Are Not:

04/15/2025

Page 3 of 3

- Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
 - o What specific deficiency or deficiencies you disagree with;
 - o Why you disagree with each deficiency; and
 - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
 - o Send your request to:

Email: RCSIDR@dshs.wa.gov; or

Fax: (360) 725-3225

If You Have Any Questions:

- Please contact me at (509)323-7315.

Sincerely,



Jessica Salquist, Regional Administrator
Region 1, Unit B
Residential Care Services

Enclosure

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