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 Compliance Determination 33627 (12/13/2023), which included complaint number(s) 108303, 108278.
The Department completed a complaint investigation of your Assisted Living Facility on 12/13/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Anne Sinclair, NCI Community Complaint Investigator

Consultation:

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(2) The resident or his or her legal representative has the right:

(a) Upon an oral or written request, to access all records pertaining to himself or herself including clinical records within twenty-four hours; and

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

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

A resident representative had requested resident records. Facility had sent resident representative records after initial 24-hour request period had exceeded.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:
- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:
- Inspect the facility to determine if you have corrected all deficiencies.

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:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:
- Please contact me at (509)993-7821.

Sincerely,

S. M

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: North Point Village, Assisted Living & Memory Care **Provider Type:** Assisted Living Facility
License/Cert.#: 2479
Intake ID: 108278
Compliance Determination #: 33627
Region/Unit #: RCS Region 1 / Unit B
Investigator: Anne Sinclair
Investigation Date(s): 12/07/2023 through 12/13/2023
Complainant Contact Date(s): 12/05/2023, 12/13/2023

Allegation(s):

1. Resident fall.
2. Resident airmattress non-working.
3. Resident wandering.
4. Facility communication.

Investigation Methods:

Sample:	Total residents: 92 Resident sample size: 6 Closed records sample size: 1
Observations:	Residents Activities Staff to resident interactions Resident to resident interactions Resident rooms Dining
Interviews:	Sample residents Health and wellness specialist Two caregivers Medtech Memory Care Director Executive Director Resident care coordinator
Record Reviews:	Sample resident care plan/face sheet Disclosure of services Characteristic roster Staff roster

Investigation Summary:

1. Facility staff responded to resident fall and provided for resident safety. Interview and record review showed the facility had failed to notify resident's hospice nurse of fall. Named resident's representative was notified, but experienced communication concerns related to incident. Facility had recent survey and were cited for WAC 388-

78A-2640(1)(a) Reporting significant change in resident condition.
2. Staff interviewed reported a process of communication with hospice provider related to equipment needs for resident use at facility. One staff reported operating named resident mattress bed of/on to assist with alarm, and caregiving staff were not aware of concerns related to named residents mattress non-functioning at time of unannounced facility visit. Named resident representative had contacted mattress supplier at will upon discovery of concerns with mattress, communicated to staff, and mattress was serviced by outside technician. Findings do not support failed facility practice.
3. Staff interviewed were aware of resident wandering behaviors and had a process to redirect resident as needed. Resident was observed wandering, pleasantly confused, engaging with staff and other residents during unannounced facility visit. Record review showed resident behaviors were addressed in their negotiated service agreement. Staff were observed readily available and assisting residents during unannounced facility visit. Staff had redirected resident from named resident room without incident during episode of wandering. Findings do not support failed facility practice.
4. Collateral contact interviewed stated named resident's representative had not received requested documentation from facility related to resident's recent fall in a timely manner. Staff interviewed during unannounced facility visit reported a process to address requests for records, addressed communication regarding record request between staff, and facility had sent requested records to named resident's representative via certified mail. Resident representative interviewed verified they had received requested records from facility. Consultation provided under RCW 70.129.030(2)(a)

Conclusion / Action:

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