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

12/02/2024

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 letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 51010 (Completion Date 12/02/2024) and 46417 (Completion Date 10/04/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/02/2024 and found no deficiencies.

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

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

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

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

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(b) Verify staff persons' work references prior to hiring;

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration

Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

The Department staff who did the On Site verification:

Patricia Eddy, Community Licensor
Carla Rose, NCI Community Licensor

If you have any questions, please contact me at (509)323-7315.

Sincerely,

J Salquist

Jessica Salquist, Field Manager
Region 1, Unit B
Residential Care Services

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 # 46417
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 1 of 13	Licensee: PSL Associates, LLC	10/04/2024

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site follow-up on 08/26/2024, 08/27/2024, 08/28/2024, 08/29/2024, 08/30/2024, 09/04/2024, 09/05/2024, 09/06/2024, 09/18/2024, and 09/09/2024 of:
North Point Village, Assisted Living & Memory Care
1110 E Westview Ct
Spokane, WA 99218

This document references the following SOD dated: 10/04/2024

The following sample was selected for review during the unannounced on-site visit: 20 of 98 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Tethra Wales, Assisted Living Facility Licensor
Veronica Jackson, Assisted Living Facility Licensor
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

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.

Stephanie Jones

Residential Care Services

10/16/2024

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

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 08/26/2024, 08/27/2024, 08/28/2024, 08/29/2024, 08/30/2024, 09/04/2024, 09/05/2024, 09/06/2024, 09/18/2024, and 09/09/2024 of:
North Point Village, Assisted Living & Memory Care
1110 E Westview Ct
Spokane, WA 99218

This document references the following SOD dated: 10/04/2024

The following sample was selected for review during the unannounced on-site visit: 20 of 98 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Tethra Wales, Assisted Living Facility Licensor
Veronica Jackson, Assisted Living Facility Licensor
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

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 _____

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) 10/18/24 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;

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to thoroughly investigate, document investigative findings, and take action to prevent recurrence for 1 of 1 resident (Resident 3) threatened with the withholding of food and water, 1 of 1 resident (Resident 19) who was left unchanged and soiled, and 1 of 1 resident (Resident 8) who had an unwitnessed fall. These failures placed Resident 3 at risk of psychosocial harm, placed Resident 19 at risk of diminished dignity and risk for infection, and placed Resident 8 at risk of future falls.

Findings Included....

WAC 388-78A-2020 defines abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult. The WAC states that in instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. The WAC further states that abuse includes mental abuse, physical abuse, personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. The WAC states that mental abuse includes humiliation, threats, intimidation, ridiculing, swearing, and yelling. The WAC defines neglect as a pattern of conduct or inaction resulting in the failure to provide the goods and services that maintain physical or mental health of a resident, or that fails to avoid or prevent physical or mental harm or pain to a resident.

In an interview on 09/09/2024 at 1:44 PM, Staff A, Executive Director, stated that they did not have a template for investigations or a system in place to ensure that investigations were completed and that all the required components of an investigation

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-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to thoroughly investigate, document investigative findings, and take action to prevent recurrence for 1 of 1 resident (Resident 3) threatened with the withholding of food and water, 1 of 1 resident (Resident 19) who was left unchanged and soiled, and 1 of 1 resident (Resident 8) who had an unwitnessed fall. These failures placed Resident 3 at risk of psychosocial harm, placed Resident 19 at risk of diminished dignity and risk for infection, and placed Resident 8 at risk of future falls.

Findings Included….

WAC 388-78A-2020 defines abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult. The WAC states that in instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. The WAC further states that abuse includes mental abuse, physical abuse, personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. The WAC states that mental abuse includes humiliation, threats, intimidation, ridiculing, swearing, and yelling. The WAC defines neglect as a pattern of conduct or inaction resulting in the failure to provide the goods and services that maintain physical or mental health of a resident, or that fails to avoid or prevent physical or mental harm or pain to a resident.

In an interview on 09/09/2024 at 1:44 PM, Staff A, Executive Director, stated that they did not have a template for investigations or a system in place to ensure that investigations were completed and that all the required components of an investigation

were addressed.

<Resident 3>

Review of a Negotiated Service Plan (the facility's titled Negotiated Service Agreement, NSA) for Resident 3, dated 06/20/2024, showed they had diagnoses including [redacted], and [redacted]. The NSA showed that Resident 3's long term memory appeared impaired, their short-term memory was poor, that they had an altered attention span, impaired ability to make decisions, decreased problem-solving skills, and decreased ability to reason. The NSA further showed that Resident 3 had a history of refusal of care and non-compliance. The NSA stated that when Resident 3 refused, staff were to speak with them in a calm voice, allow them additional time through re-approach, have a different staff member attempt, and use visual cues. The NSA further stated that Resident 3 required one person assistance with most shower activities, including transfer into and out of the shower.

Review of an Employee Statement/Concern Form, dated 08/10/2024, showed that Staff M, Care Partner, reported an incident at 10:15 AM on 08/10/2024 involving Staff O. The form showed that Staff O told Resident 3 they could not have breakfast, food or water, following an incident of aggression. The form showed that the incident was considered resident abuse by the witness (Staff M). Staff N, Care Partner, was also listed as a witness on the form. Further review showed that Staff O made the comment due to feeling it was okay to force showers because, "They (Resident 3) are not right in the head." The form showed that Staff O stated they were able to enforce punishment when assaulted by a resident. The form showed that Staff B, Health and Wellness Specialist, Staff I, Memory Care Director, and Staff C, Resident Care Coordinator were notified.

In an interview on 09/06/2024 at 12:25 PM, Staff M stated that they had been training Staff O when the incident occurred. Staff M stated that after being hit by Resident 3, Staff O said, "No food or water for [them]" directly to Resident 3. Staff M stated they filled out a grievance form and wrote a statement on the back side of the form. Staff M stated that they were never asked anything about the incident by anyone in management. Staff M stated they were not asked to do any additional training with Staff O and were not aware of any measures put in place to prevent reoccurrence.

In an interview on 09/06/2024 at 12:46 PM, Staff N stated that they were present for the incident on 08/10/2024 between Staff O and Resident 3. Staff N stated that they had heard a commotion in the living room and walked over. Staff N stated that Resident 3 did not want to take a shower and became aggressive. Staff N stated that Resident 3 slapped Staff M and punched Staff O. Staff N stated that after Resident 3 punched Staff O, Staff O backed up and said to Resident 3, "No food or water for you." Staff N stated that it was said directly to Resident 3 in front of the caregivers and another

resident. Staff N stated that they wrote out a statement and put it on Staff C's desk. Staff N stated that later in the shift they participated in a conversation between Staff C and Staff O (both on cell phones). Staff N stated there was no further follow up regarding the incident or their statement.

In an interview on 08/30/2024 at 9:48 AM, Staff C stated that they completed the investigation after Staff A and Staff B notified them of the incident. Staff C stated that they obtained a statement from Staff O, with Staff N present. Staff C stated that Staff O said how they responded to Resident 3 was how they were trained where they worked previously. Staff C stated that they asked Staff M, Staff N, and Staff E, Med Aide, to give written statements to Staff I. Memory Care Director. Staff C stated that they conducted no further investigation. When asked what interventions were put in place to prevent reoccurrence, Staff C stated that they asked a caregiver to go over a list of things with Staff O. When the list of training topics was requested, Staff C stated that there was not a specific list and that they asked the caregiver to "let [Staff O] know how to navigate these situations." Staff C further stated no changes were made to Staff O's training or work schedule.

Review of the "actual worked" staff schedule for August 2024 showed that Staff O worked 08/15/2024, 08/16/2024, 08/17/2024, 08/18/2024, 08/22/2024, 08/23/2024, 08/24/2024, 08/25/2024, 08/29/2024, 08/30/2024, and 08/31/2024, with no changes made to their schedule by the facility following the incident with Resident 3 on 08/10/2024.

In an interview on 08/26/2024 at 4:00 PM, Staff A stated that the most recent grievance received about Staff O was regarding training Staff O received at a previous facility to deny food or water if a resident had behaviors. Staff A stated they had a conversation with Staff O right away. Staff A stated they documented all of that in an internal investigation. When a copy of the investigation was requested, Staff A stated they definitely documented the conversation they had with Staff O and could provide a copy of that documentation.

Review of a word document, dated 08/10/2024 and presented to the department as documentation of the corrective conversation had with Staff O, showed narrative of Staff C's interview of Staff O following the incident. Further review showed that it read "Staff reported that [Staff O] had stated [they] were trained to withhold food and water when a resident was experiencing a moment of challenging behaviors as punishment for the behavior." Further review showed that Staff C told Staff O those statements were not appropriate and that a staff was "going to stay back" to help Staff O understand better ways to navigate similar situations. The form did not specify which staff would be responsible to help Staff O and what training was to be covered. Further review showed no reference to Staff A's participation in the conversation and that Staff A's signature did not appear on the form.

Review of facility records showed there was no documentation of an investigation of Staff O's alleged abuse toward Resident 3. The records failed to indicate that the facility implemented efforts to protect residents during the course of an investigation

or instituted measures to prevent continued abuse of residents.

<Resident 8>

Review of Resident 8's NSA, dated 07/26/2024, showed that Resident 8 had a diagnosis of [redacted] and used a walker or wheelchair for mobility. Further review showed that Resident 8 was a high risk for falls due to cognitive impairment, history of multiple falls and required a motion sensor alarm for safety.

In an interview on 08/29/2024 at 2:02 PM, Staff F, Connections Care Coordinator, stated that on 08/07/2024 Resident 8 had a fall while outdoors. Staff F stated that on the next day, 8/08/2024, had fallen again while outdoors. Staff F stated the fall on 08/08/2024 required emergency response and a emergency room evaluation.

Review of an incident report, dated 08/08/2024, showed that staff observed Resident 8 fall down in the outside courtyard after they lost their balance. The report showed that Resident 8 told staff that they were cold and that their head hurt. The report showed that Resident 8 was alone at the time of the fall. The report showed that 911 was called and that Resident 8 was transported to the hospital.

Review of Resident 8's hospital After Visit Summary, dated 08/08/2024, showed diagnoses of [redacted] and [redacted]."

In an interview on 09/06/2024 at 12:35 PM, Staff M stated that they were working on 08/08/2024 when Resident 8 fell outside. Staff M further stated that no one in management asked them any questions about the fall. Staff M stated that they were not aware of any changes to the resident's NSA.

In an interview on 09/05/2024 at 11:28 AM, Staff E, Medication Aide, stated that Resident 8 fell outside on 08/07/2024 and an ambulance responded. Staff E stated that Resident 8 was evaluated by emergency responders and remained at the facility. Staff E stated that Resident 8 had another fall outside the following morning on 08/08/2024, around breakfast. Staff E stated that an ambulance responded and the resident was taken to the hospital. Staff E stated that they completed an incident report for the fall on 08/08/2024 but forgot to do an incident report for the fall on 08/07/2024. Staff E stated that they notified Staff A, Staff B, Staff C, and Staff D about the fall on 08/07/2024, by group text. Staff E stated that the group text was regularly utilized to provide updates to management about residents.

Observation of a text message, dated 08/07/2024 at 2:45 PM and sent to Staff A, Staff B, Staff C, and Staff D, by Staff E showed that it read, "[Resident 8] found outside on the floor. POA called. 911 called." Observation also showed a reply received from Staff B at 7:45 PM that read, "Just saw this. Was [they] sent out or remained in community." A reply from Staff E read "Remained in community. Thank you."

In an interview on 09/04/2024 at 12:24 PM, Staff B stated they located the group text sent by Staff E but only received an incident report for the second fall that occurred on 08/08/2024. Staff B stated they did not investigate the fall on 08/07/2024 because they did not receive an incident report.

Review of facility records showed there was no documentation of investigations for Resident 8's fall on 08/07/2024 or 08/08/2024.

<Resident 19>

Review of Resident 19's NSA, dated 09/03/2024, showed that Resident 19 had a diagnosis of [redacted]. The NSA showed that Resident 19 required bathroom assistance during the day and night and that the "Resident will maintain cleanliness and dignity."

Review of an Employee State/Concern Form, dated 08/06/2024, showed that Staff U, Care Partner, had concerns about care provided by Staff P, Care Partner. Review of the form showed that Staff U stated that Staff P neglected residents and was careless. The form showed that Staff U stated that Staff P was aware of Resident 19 needing a brief change due to soiling themselves that morning. The form showed that Staff U later found the resident still soiled with dried feces on the resident's buttocks, legs and genitals, when they returned from assisting a different cottage. Staff U identified Resident 19 by room number on the form. Further review showed that Staff H, Care Partner, was identified as a witness.

In an interview on 08/26/2024 at 4:00 PM, Staff A, stated most of the grievances they received about Staff P were, "staffing issues," including being on their phone and "staying in the bathroom a lot." Staff A stated they "were not issues with type of care. Lack of care maybe."

In an interview on 09/25/2024 at 2:30 PM, Staff U stated they had concerns regarding Staff P's care and treatment of residents in the facility's memory care units. Staff U stated that they discussed with management and filled out three "very detailed" grievance forms that they provided to facility managers regarding Staff P's poor work performance, estimating that they did so in July or August 2024. Staff U stated they gave the grievance forms to Staff A and Staff C but said their concerns weren't addressed. Staff U stated that Staff P neglected to provide residents with the care they needed. Staff U stated that Staff P left Resident 19 soiled with feces after Staff U asked Staff P "multiple times" to provide the needed incontinence care to Resident 19. Staff U stated that as a result, they found Resident 19 still soiled. Staff U stated that Staff P was frequently on their phone, leaving residents without the care they needed.

In an interview on 09/09/2024 at 10:57 AM, Staff H, identified as a witness to incident

on Employee State/Concern Form dated 08/06/2024, stated that they were never interviewed or questioned by management regarding the incident.

Review of an Employee State/Concern Form, dated 08/11/2024, showed that Staff J, Care Partner, had concerns regarding Staff P not providing incontinence care to Resident 19. Further review of the form showed that Staff J reported that Staff P was often "every shift," in the kitchen on their phone which resulted in resident neglect.

Review of the "actual worked" staff schedule for August 2024 showed that Staff P worked on 08/09/2024, 08/10/2024, 08/11/2024, 08/16/2024, and 08/17/2024 with no changes made to their schedule by the facility.

Review of facility records showed there was no documentation of an investigation for Staff P's alleged neglect of Resident 19. The records failed to indicate that the facility instituted appropriate measures to prevent continued neglect of residents or implemented efforts to protect resident during the course of an investigation.

This is an uncorrected deficiency previously cited 06/21/2024 and a recurring deficiency previously cited on 12/28/2022 for subsections (1) (2).

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) 11/18/24

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

Administrator (or Representative) — Date 10/18/24

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(b) Verify staff persons' work references prior to hiring;

This requirement was not met as evidenced by:

on Employee State/Concern Form dated 08/06/2024, stated that they were never interviewed or questioned by management regarding the incident.

Review of an Employee State/Concern Form, dated 08/11/2024, showed that Staff J, Care Partner, had concerns regarding Staff P not providing incontinence care to Resident 19. Further review of the form showed that Staff J reported that Staff P was often "every shift," in the kitchen on their phone which resulted in resident neglect.

Review of the "actual worked" staff schedule for August 2024 showed that Staff P worked on 08/09/2024, 08/10/2024, 08/11/2024, 08/16/2024, and 08/17/2024 with no changes made to their schedule by the facility.

Review of facility records showed there was no documentation of an investigation for Staff P's alleged neglect of Resident 19. The records failed to indicate that the facility instituted appropriate measures to prevent continued neglect of residents or implemented efforts to protect resident during the course of an investigation.

This is an uncorrected deficiency previously cited 06/21/2024 and a recurring deficiency previously cited on 12/28/2022 for subsections (1) (2).

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

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(b) Verify staff persons' work references prior to hiring;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to verify staff persons' work references prior to hiring for 3 of 8 sampled staff (Staff Q, R, and S). This failure placed residents at risk of receiving care from potentially unsuitable staff.

Findings included…

<Staff Q>

Review of the facility's staff list showed a date of hire for Staff Q, Care Partner, of 08/07/2024.

Review of Staff Q's reference record showed:

- Reference 1, date contacted 08/12/2024.
- Reference 2, message left 08/12/2024.
- Reference 3, date contacted 08/12/2024.

In an interview on 08/27/2024 at 3:10 PM, Staff T, Concierge, confirmed that references 1 and 3 were contacted on 08/12/2024 (after hire) and that reference 2 never called back.

<Staff R>

Review of the facility's staff list showed a date of hire for Staff R, Care Partner, of 08/06/2024.

Review of Staff R's reference record showed:

- Reference 1, date contacted box was empty.
- Reference 2, date contacted box was empty.
- Reference 3, date contacted box was empty.

In an interview on 08/27/2024 at 3:10 PM, Staff T confirmed that no contact with Staff R's references were made. Staff T stated that they did not have phone numbers for the contacts and that the employee had decided it was not a good fit and were no longer employed.

Review of the staff schedule for August 2024 showed that Staff R was scheduled to work NOC shift 08/12/2024-08/15/2024, 08/19/2024-08/22/2024, and 08/26/2024-

08/29/2024.

In an interview on 09/12/2024 at 10:35 AM, Staff G, Business Office Director, stated that Staff R's last day of work was 08/25/2024.

<Staff S>
Review of the facility's staff list showed a date of hire for Staff S, Medication Aide, of 08/25/2024.

Review of Staff S' reference record showed:

- Reference 1, date contacted 08/27/2024.
- Reference 2, message left 08/27/2024.
- Reference 3, message left 08/27/2024.

In an interview on 08/27/2024 at 3:10 PM, Staff T confirmed that reference 1 was contacted on 08/27/2024, and that messages were left for references 2 and 3. Staff T confirmed that all attempts to reach reference for Staff S were conducted earlier that day.

This is an uncorrected deficiency previously cited on 06/21/2024.

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) 11/18/24.

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

Administrator (or Representative) — Date: 10/18/24

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial

08/29/2024.

In an interview on 09/12/2024 at 10:35 AM, Staff G, Business Office Director, stated that Staff R's last day of work was 08/25/2024.

<Staff S>
Review of the facility's staff list showed a date of hire for Staff S, Medication Aide, of 08/25/2024.

Review of Staff S' reference record showed:

- Reference 1, date contacted 08/27/2024.
- Reference 2, message left 08/27/2024.
- Reference 3, message left 08/27/2024.

In an interview on 08/27/2024 at 3:10 PM, Staff T confirmed that reference 1 was contacted on 08/27/2024, and that messages were left for references 2 and 3. Staff T confirmed that all attempts to reach reference for Staff S were conducted earlier that day.

This is an uncorrected deficiency previously cited on 06/21/2024.

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)_____ .

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

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial

exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report incidents of alleged abuse and neglect to the Complaint Resolution Unit for 2 of 20 residents (Resident 3 and 19). This failure placed residents at increased risk for mental abuse and neglect by delaying the department's ability to investigate the alleged abuse and neglect, and placed residents at risk of psychosocial harm.

Findings included…

Review of the facility's policy titled, "Abuse and Neglect Reporting Guidelines," last revised 12/2023, showed that it stated if abuse is suspected, to contact appropriate State agency during the same shift the incident is discovered and follow all state regulation reporting procedures. The policy defined "abuse" as "any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a resident." The definition outlined types of abuse, including "a threat or menacing conduct directed toward a resident that results or might reasonably be expected to result in fear or emotional or mental distress to a resident." The policy further stated that abuse complaints should be viewed as very serious and that it is the policy to act upon and report any complaints of abuse. The policy defined "neglect" as "the failure or omission by oneself, caretaker, or another person with a duty to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness."

In an interview on 08/26/2024 at 4:00 PM, Staff A, Executive Director, stated that they did not have a system to track and ensure if and when incidents and concerns about abuse or neglect were reported to the Complaint Resolution Unit (CRU).

In an interview on 08/26/2024 at 11:50 AM, Staff D, Resident Care Coordinator, stated that when a report was made to CRU it was documented in the resident's chart notes.

<Resident 3>

Review of a Negotiated Service Plan (the facility's titled Negotiated Service Agreement, NSA) for Resident 3, dated 06/20/2024, showed they had diagnoses including [redacted], and [redacted]. The NSA showed that Resident 3's long term memory appeared impaired, their short-term memory was poor, that they had altered attention span, impaired ability to make decisions, decreased problem-solving skills, and decreased ability to reason. The NSA further showed that Resident 3 had a history of refusal of care and non-compliance. The

NSA stated that when Resident 3 refused, staff were to speak with them in a calm voice, allow them additional time through re-approach, have a different staff member attempt, and use visual cues. The NSA further stated that Resident 3 required one person assistance with most shower activities, including transfer into and out of the shower.

Review of an Employee Statement/Concern Form, dated 08/10/2024, showed that the Staff M, Care Partner, reported an incident that occurred at 10:15 AM on 08/10/2024 involving Staff O, Care Partner. The form showed that Staff O stated, “No food or water for [them],” following an altercation with Resident 3. The form showed that Staff O felt their verbal response was appropriate due to Resident 3 becoming aggressive. The form showed the incident was reported to Staff B, Health and Wellness Specialist, and Staff I, Memory Care Director.

In an interview on 09/06/2024 at 12:25 PM, Staff M stated that when struck by Resident 3, Staff O said, “No food or water for [them],” directly to Resident 3. Staff M stated they filled out a grievance form and wrote a statement on the back side of the form.

In an interview on 09/06/2024 at 12:46 PM, Staff N, Care Partner, stated that they were present for the incident between Staff O and Resident 3, that occurred on 08/10/2024. Staff N stated that after Resident 3 punched Staff O, Staff O told the resident they could not have any food or water. Staff N stated that it was said directly to Resident 3 in front of the caregivers and another resident. Staff N stated that they wrote out a statement and put it on Staff C’s desk. Staff N stated that later in the shift they participated in a conversation between Staff C and Staff O (both on cell phones). When asked if they reported the incident to the State, Staff N stated they did not because Staff M said they had reported it.

In an interview on 09/09/2024 at 1:44 PM, Staff A stated that they did not report the alleged verbal abuse of Resident 3 by Staff O because “it never happened.”

In an interview on 08/30/2024 at 9:48 AM, Staff C stated that they had not made any reports to the state.

Review of August 2024 chart notes for Resident 3 showed no documentation of a report made to the state.

Review of the department’s reporting database showed no facility or facility staff reports related to the alleged verbal abuse of Resident 3 by Staff O.

In an interview on 09/06/2024 at 2:15 PM, Staff B stated that the incident with Staff O had been brought to their attention and that they had not reported it.

<Resident 19>

Review of Resident 19's NSA, dated 09/03/2024, showed that Resident 19 had a diagnosis of [redacted]. The NSA further showed that Resident 19 required bathroom assistance during the day and night and that the "Resident will maintain cleanliness and dignity."

In an interview on 09/25/2024 at 2:30 PM, Staff U, Care Partner, stated they reported concerns and filled out three grievance forms in July or August of 2024, regarding Staff P, Care Partner. Staff U stated they gave the grievance forms to Staff A, Executive Director, and Staff C, Resident Care Coordinator. Staff U stated that Staff P left Resident 19 soiled with feces after Staff U asked Staff P "multiple times" to provide the needed incontinence care to Resident 19. Staff U stated that they found Resident 19 soiled with dried feces, later that day after asking Staff P to provide incontinence care.

Review of an Employee State/Concern Form, dated 08/06/2024, showed that Staff U stated that Staff P neglected residents and was careless. Staff U identified Resident 19 by room number on the form.

Review of an Employee State/Concern Form, dated 08/11/2024, showed that Staff J, Care Partner, reported to management that Staff P stayed on their phone and neglected Resident 19 by not providing incontinence care. The form showed that Staff J stated that they had been told to stop writing grievances.

Review of August 2024 chart notes for Resident 19 showed no documentation of a report made to the state.

Review of the department's reporting database showed no facility or facility staff reports related to the alleged neglect of Resident 19 by Staff P.

In an interview on 09/09/2024 at 1:44 PM, Staff A stated they did not report concerns about residents being left in soiled clothes or not being changed and that it was an "internal issue."

This is an uncorrected deficiency previously cited on 06/21/2024.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2479	Compliance Determination # 46417
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page of 13	Licensee: PSL Associates, LLC	10/04/2024

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) 11/18/24.

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

Administrator (or Representative) — Date: 10/18/24

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

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: 118158
Compliance Determination #: 37222
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 02/22/2024 through 06/21/2024
Complainant Contact Date(s): 03/11/2024, 04/25/2024

Allegation(s):

1. Witnessed fall.
2. Poor facility communication.
3. Inadequate staffing.
4. Missing items.

Investigation Methods:

Sample:
Total residents: 93
Resident sample size: 14
Closed records sample size: 3

Observations:
Alleged Victim
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration
Dining

Interviews:
Executive Director
Regional Nurse
Alleged Victim
Residents
Care Partners
Medication Technicians
Alleged Victim's Representative
Resident Representatives
Business Office Manager
Memory Care Coordinator

Record Reviews:
Disclosure of Services
Characteristic roster
Staff roster
Resident face sheets
Resident care plans
Incident reports

Progress notes
Reporting of Incidents/Incident Reports Policy
Grievance Policy
Fall Response Policy
Resident Rights Policy
Staff training documentation
Grievances
Staff schedule
Staff re-training
Abuse, Neglect and Exploitation Policy
Hospital after-visit summary
Incident investigation
Facility safety plan

Investigation Summary:

1. Review of the Alleged Victim’s negotiated service agreement showed they had high care needs, required extensive supervision, and were at significant risk for falls. Observations of memory care staffing showed there was inadequate staff to meet the resident’s identified needs. Failed practice was cited under WAC 388-78A-2450 Staff (1)(a)(2)(b).
2. The facility had a system to ensure adequate documentation was sent with residents when they were sent out of the facility for medical care. Interviews with resident representatives showed they had no concerns with lack of provided documentation. Document review showed staff attempted notification of the Alleged Victim's Representative when they were sent out for care. The Alleged Victim reported feeling safe in the facility. No failed facility practice.
3. Review of the Alleged Victim's negotiated service agreements showed they had high care needs, required extensive supervision, and were at significant risk for falls. Observations of memory care staffing showed there was inadequate staff to meet the residents' identified needs. Failed practice was cited under WAC 388-78A-2450 Staff (1)(a)(2)(b).
4. The facility had a plan to replace the Alleged Victim's missing items. Interview with the Alleged Victim's Representative showed they had not reached out to the facility to determine if the replacement items had arrived or not. Facility staff were encouraging families to initial resident belongings when brought to the facility. No failed facility practice.

Conclusion / Action:

- [x] 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 Living & Memory Care **Provider Type:** Assisted Living Facility
License/Cert.#: 2479
Intake ID: 122956
Compliance Determination #: 37222
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 02/22/2024 through 06/21/2024
Complainant Contact Date(s):

Allegation(s):
Resident abuse by staff.

Investigation Methods:

Sample:
Total residents: 93
Resident sample size: 14
Closed records sample size: 3

Observations:
Alleged Victim
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration
Dining

Interviews:
Alleged Victim
Alleged Victim's Representative
Care Partners
Executive Director
Health and Wellness Specialist
Business Office Manager
Medication Technicians
Residents
Resident Representatives
Memory Care Coordinator

Record Reviews:
Disclosure of Services
Characteristic roster
Staff roster
Resident face sheets
Resident care plans
Incident reports
Progress notes
Reporting of Incidents/Incident Reports Policy
Grievance Policy

Fall Response Policy
Resident Rights Policy
Staff training documentation
Grievances
Staff schedule
Staff re-training
Abuse, Neglect and Exploitation Policy
Hospital after-visit summary
Facility safety plan
Incident investigations
Facility Residency Agreement
Associate Handbook

Investigation Summary:

Interviews with staff showed that the alleged abuse and neglect of multiple residents by staff, went unaddressed by facility management. Failed practice was cited under WAC 388-78A-2371 Investigations (1)(2)(3)(4). Failed practice was cited under WAC 388-78A-2600 Policies and procedures (2)(r). Failed practice was cited under WAC 388-78A-2630 Reporting abuse and neglect (1)(a)(b), and WAC 388-78A-2660 Resident rights (1)(2)(3)(4).

Conclusion / Action:

- [x] 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 Living & Memory Care **Provider Type:** Assisted Living Facility
License/Cert.#: 2479
Intake ID: 123254
Compliance Determination #: 37222
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 02/22/2024 through 06/21/2024
Complainant Contact Date(s):

Allegation(s):
Residents abused by staff.

Investigation Methods:

Sample:
Total residents: 93
Resident sample size: 14
Closed records sample size: 3

Observations:
Alleged Victims
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration
Dining

Interviews:
Alleged Victim
Alleged Victim's Representatives
Care Partners
Executive Director
Health and Wellness Specialist
Business Office Manager
Medication Technicians
Residents
Resident Representatives
Memory Care Coordinator

Record Reviews:
Disclosure of Services
Characteristic roster
Staff roster
Resident face sheets
Resident care plans
Incident reports
Progress notes
Reporting of Incidents/Incident Reports Policy
Grievance Policy

Fall Response Policy
Resident Rights Policy
Staff training documentation
Grievances
Staff schedule
Staff re-training
Abuse, Neglect and Exploitation Policy
Hospital after-visit summary
Facility safety plan
Incident investigations
Facility Residency Agreement
Associate Handbook

Investigation Summary:

Interviews with staff showed that the alleged abuse and neglect of multiple residents by staff, went unaddressed by facility management. Failed practice was cited under WAC 388-78A-2371 Investigations (1)(2)(3)(4). Failed practice was cited under WAC 388-78A-2600 Policies and procedures (2)(a). Failed practice was cited under WAC 388-78A-2630 Reporting abuse and neglect (1)(a)(b), and WAC 388-78A-2660 Resident rights (1)(2)(3)(4).

Conclusion / Action:

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

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

Statement of Deficiencies	License #: 2479	Compliance Determination #37222
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 1 of 35	Licensee: PSL Associates, LLC	06/21/2024

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 02/22/2024, 02/22/2024, 03/18/2024 and 03/19/2024 of:

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

This document references the following complaint number(s): 118158, 122856, 123264

The following sample was selected for review during the unannounced on-site visit: 14 of 93 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

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

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 — 07/03/2024 Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

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

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 02/22/2024, 02/22/2024, 03/15/2024 and 03/19/2024 of:

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

This document references the following complaint number(s): 118158, 122956, 123254

The following sample was selected for review during the unannounced on-site visit: 14 of 93 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

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

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 _____

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.

Statement of Deficiencies	License #: 2479	Compliance Determination # 37222
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 2 of 35	Licensee: PSL Associates, LLC	06/21/2024

Administrator (or Representative) 7/11/24 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;

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate alleged incidents of resident abuse and neglect by a staff member, determine the circumstances, implement measures to prevent harm, and protect residents during the investigation for 3 of 8 residents (Residents 1, 2, and 5). These failures resulted in ongoing allegations of resident abuse and neglect, the alleged perpetrator having unsupervised access to residents, and placed residents at risk for psychosocial and physical harm.

Findings included...

WAC 388-78A-2020 defines abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult. The WAC states that in instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. The WAC further states that abuse includes mental abuse, physical abuse, personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. The WAC states that physical abuse includes physical mistreatment and mental abuse includes humiliation, harassment, intimidation, ridiculing, swearing, and yelling. The WAC states that improper use of restraint includes physical restraint for convenience or discipline.

Review of the facility's policy titled, "Abuse, Neglect and Exploitation," dated 11/2018, showed it stated when abuse was suspected, facility staff were to act immediately to protect the residents from additional harm. The policy further stated that an incident report was to be completed, appropriate documentation was to be entered into the resident's service notes, and an investigation was to be initiated.

Review of the facility's policy titled, "Reporting of Incidents/Incident Reports," last revised

Administrator (or Representative) 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;

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate alleged incidents of resident abuse and neglect by a staff member, determine the circumstances, implement measures to prevent harm, and protect residents during the investigation for 3 of 8 residents (Residents 1, 2, and 5). These failures resulted in ongoing allegations of resident abuse and neglect, the alleged perpetrator having unsupervised access to residents, and placed residents at risk for psychosocial and physical harm.

Findings included…

WAC 388-78A-2020 defines abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult. The WAC states that in instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. The WAC further states that abuse includes mental abuse, physical abuse, personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. The WAC states that physical abuse includes physical mistreatment and mental abuse includes humiliation, harassment, intimidation, ridiculing, swearing, and yelling. The WAC states that improper use of restraint includes physical restraint for convenience or discipline.

Review of the facility's policy titled, "Abuse, Neglect and Exploitation," dated 11/2018, showed it stated when abuse was suspected, facility staff were to act immediately to protect the residents from additional harm. The policy further stated that an incident report was to be completed, appropriate documentation was to be entered into the resident's service notes, and an investigation was to be initiated.

Review of the facility's policy titled, "Reporting of Incidents/Incident Reports," last revised

on 05/10/2022, showed it stated all incident reports were to include outcomes and follow up measures that would allow for interventions to help reduce future risk.

Review of an employee statement/concern form, dated 01/31/2024, showed Staff I, Care Partner, observed Staff P, Care Partner, left all memory care residents in B Cottage unattended on 01/31/2024. The form showed Staff I was concerned for resident safety because B Cottage residents were at high risk for falls. The form showed Staff L, Care Partner, also witnessed Staff P leave the residents unattended. The form was initialed as received by Staff D, Business Office Manager, on 01/31/2024, indicating facility management was aware of the unsupervised memory care residents.

Review of an employee statement/concern form, dated 01/31/2024, showed that on 01/31/2024 at 8:50 AM, Staff L witnessed Staff P leave a memory care cottage while no other staff were present, leaving the residents in the cottage by themselves. The form showed the incident was witnessed by two other staff, including Staff I. The form was initialed as received by Staff D on 01/31/2024, indicating facility management was aware of the unsupervised memory care residents.

Review of facility documents showed no investigation was done regarding Staff P leaving residents unattended in the memory care cottages.

In an interview on 03/14/2024 at 9:34 AM, Staff E, Medication Technician, stated they handed in four written grievances about two months ago, directly to Staff D for concerns staff had about Staff P's mistreatment of the residents. Staff E stated they were never interviewed as part of an investigation by management regarding their concerns. Staff E stated they did not believe the other staff who turned in concerns related to Staff P mistreating residents, had been interviewed either. Staff E stated they did not believe Staff P was ever suspended for mistreatment of the residents because Staff P never had more than one day off in a row. Staff E stated grievances, including abuse-related concerns, were supposed to be put in a box outside Staff A's, Executive Director, or Staff D's doors.

The department investigator requested the above grievances from Staff A and none were provided.

In an interview on 03/14/2024 at 11:02 AM, Staff C, Memory Care Coordinator, stated Staff P was never suspended (to protect residents during the course of an investigation) prior to the date of the interview for mistreating residents pending a facility investigation of any kind.

In an interview on 03/15/2024 at 9:41 AM, Staff F, Care Partner, stated Staff P was verbally harsh and abrasive towards residents, but the way Staff P treated residents physically, was worse. Staff F stated they and other staff told management about their concerns regarding Staff P. Staff F stated they were never interviewed by management about their concerns regarding Staff P even though they turned in a grievance about Staff P's mistreatment of a resident. Staff F stated they did not think Staff P was ever suspended or removed from the

schedule for their mistreatment of the residents.

In an interview on 03/15/2024 at 10:04 AM, Staff G, Medication Technician, stated Staff P was very mean to residents and there were many grievances on Staff P. Staff G stated they did not believe Staff P was ever suspended. Staff G stated they were never interviewed by management regarding the concerns they reported about Staff P, and the issue had been “brushed aside.”

In an interview on 03/15/2024 at 5:05 PM, Staff A stated they had never received a written grievance related to Staff P and they had never done an investigation related to Staff P.

Review of an email sent by Staff A to the department investigator, on 03/16/2024 at 12:04 PM, showed that Staff P was allowed to work at the facility routinely until they were officially suspended (for all of the allegations brought forth by staff's concerns of how residents were mistreated) on 03/16/2024.

In an interview on 03/20/2024 at 2:35 PM, Staff K stated they were never interviewed or questioned by management about their concerns related to Staff P’s mistreatment of the residents, even though they reported their concerns to Staff C who said they would tell Staff A.

In an interview on 03/22/2024 at 10:14 AM, Staff D stated staff could put their abuse-related written concerns under Staff A’s door. Staff D stated if an abuse-related concern was turned in Friday night or over a weekend, and Staff A was not in the facility on Monday, Staff D would check under Staff A’s door.

In an interview on 03/22/2024 at 3:53 PM, Staff M stated they were never questioned or talked to by management regarding concerns about Staff P’s mistreatment of the residents, even though they reported their concerns to management.

In an interview on 04/18/2024 at 5:38 PM, Staff P stated they were moved to work in the assisted living because management did not want them in memory care anymore. Staff P stated there were concerns they had been “physically forceful” and “verbally abusive” to the residents. Staff P stated they were moved to assisted living about a month before they were suspended for alleged mistreatment of residents the first time, though they continued to cover shifts in the memory care. Staff P stated their second suspension, pending a more thorough facility investigation of the previous allegations of resident mistreatment, occurred on 03/28/2024.

In an interview on 05/06/2024 at 12:59 PM, Staff D stated they called Staff A immediately after receiving three staff grievances regarding Staff P’s mistreatment of residents. Staff D stated Staff A directed them to interview the staff who turned in the grievances. Staff D stated they interviewed Staff L, Staff F, and Staff I, then scanned and emailed the grievances and interview responses to Staff A. Staff D stated they were Staff A’s designee.

The department investigator requested the above grievances and none were received.

In an interview on 05/13/2024 at 11:01 AM, Staff J, Resident Care Coordinator, stated staff were told to put resident and staff concerns on change of condition forms, that they were filed in the residents' charts, and that Staff B, Health and Wellness Specialist, removed them from the residents' charts anytime annual survey occurred.

In an interview on 05/13/2024 at 3:21 PM, Staff E stated they spoke with Staff A on 12/20/2023, 01/11/2024, and 01/25/2024 regarding Staff P ignoring the residents, their motion sensor alarms, forcing them to walk too fast, and leaving the cottages unattended. Staff E stated they recalled those dates because they had to set up a time to talk to Staff A on days Staff E was not scheduled to work. Staff E stated Staff A's response was stating they would look into it.

In an interview on 05/14/2024 at 1:23 PM, Staff A stated they recalled hearing that Staff P had been lifting a resident by their legs to provide pelvic hygiene, but Staff A could not remember who the resident was. Staff A stated they thought the reporting staff member was Staff N. Staff A stated that Staff N had already addressed the issue with Staff P and that Staff P stated that was how they changed people at the last facility they worked, so no investigation was needed.

In an interview on 05/15/2024 at 12:23 PM, Staff N stated that Staff A met with Staff P in B Cottage to address concerns about Staff P's treatment of the residents. The conversation occurred before the initiation of the state's (department) investigation (which was initiated on 02/22/2024), and while Staff P was still working in both memory care and assisted living.

Resident 1

Review of a negotiated service agreement (NSA) for Resident 1, dated 01/09/2024, showed they had Alzheimer's, a progressive disease that destroys memory and other mental functions, and situational depression. The NSA showed Resident 1 was alert to self only and they required supervision.

In an interview on 03/14/2024 at 9:34 AM, Staff E stated that about two months ago, Staff K turned in a written grievance related to Staff P ignoring the motion sensor alarms, resulting in a fall for Resident 1.

In an interview on 03/15/2024 at 10:04 AM, Staff G stated they notified Staff A immediately after witnessing Staff P pull down on Resident 1's arms to keep them in their wheelchair a few weeks prior. Staff G stated Staff A came to Resident 1's cottage and spent the remainder of the shift with Staff P.

In an interview on 05/13/2024 at 3:21 PM, Staff E stated it was in January of 2024 that they saw Staff P tipping Resident 1 back in their wheelchair. Staff E stated they told Staff C though no one ever interviewed them as part of an investigation.

In an interview on 05/14/2024 at 10:44 AM, Staff K stated that during the time they worked with Staff P (beginning in September of 2023), Staff P would regularly document that Resident 1 refused showers when they had not been offered. Staff K stated that two times, they saw Staff P go into the bathroom while Resident 1 was in there and just start taking Resident 1's clothes off then force them into the shower. Staff K stated they told Staff A and Staff B about this concern, just before Staff A's "stern conversation" with Staff P. When asked what Staff A did about it, Staff K stated that Staff A said, "Well did [Resident 1] get a shower? Then the issue is done."

Review of facility records showed there was no documentation of investigations for Staff P's alleged neglect of Resident 1's motion sensor alarm, or for Staff P allegedly restraining or physically and verbally abusing Resident 1. The records failed to indicate that the facility instituted appropriate measures to prevent continued abuse of residents or implemented efforts to protect resident during the course of an investigation of neglect by Staff P.

Resident 2

Review of an undated face sheet for Resident 2 showed they had a diagnosis of [redacted].

Review of a progress note for Resident 2, dated 10/07/2023 and written by Staff R, Medication Technician, showed care staff in B Cottage called them regarding Resident 2's protruding hip (dislocated hip) and sores on their buttocks. The note showed the resident's hospice provider and Staff B were notified of the health concerns related to Resident 2's injuries.

In an interview on 03/22/2024 at 3:53 PM, Staff M stated they were unsure if Resident 2's dislocated hip was investigated properly because nobody seemed to know how it happened. Staff M stated Resident 2 was already bedridden by the time their hip became dislocated and it occurred just a short time before Resident 2 died.

In an interview on 03/25/2024 at 2:45 PM, Collateral Contact 1 (CC1), Resident Representative, stated the facility "just kind of assumed" Resident 2's hip became dislocated while staff provided care to the resident. CC1 stated Resident 2 was on hospice when their hip became dislocated. CC1 stated Resident 2 was already almost gone (near death) at that point, they were completely bedbound, and they were "skin and bones." CC1 stated Resident 2 passed away on about [redacted]/2023.

In an interview on 03/28/2024 at 9:16 AM, Staff F stated they told Staff G, Staff C, and a

couple other staff that they saw Staff P change Resident 2 by lifting their legs up by the resident's head in early October of 2023. Staff F stated Staff C told them it would be dealt with. Staff F stated they saw Staff P change Resident 2 by lifting their legs about one week before finding out the resident's hip was dislocated, and Resident 2 died about one day after that. Staff F stated they were never interviewed by management regarding Resident 2's dislocated hip or Staff P's treatment of Resident 2.

In an email communication sent on 03/28/2024 at 6:21 PM, Staff A stated that as far as they knew, there was no investigation done on Resident 2's dislocated hip.

In an interview on 04/18/2024 at 5:38 PM, Staff P stated they were never interviewed by Staff A or other management staff related to Resident 2's hip injury.

In an interview on 05/14/2024 at 8:18 AM, Staff C stated that Staff K told them last fall, before Resident 2 died, that they saw Staff P changing Resident 2 by lifting them from under their legs. Staff C stated they told Staff P that day that that was not how they changed residents at the facility and then educated Staff P on the risks for injury. Staff C stated they explained to Staff P that staff were not to change residents in the same way you would "change a baby." Staff C stated they told Staff B about the incident.

In an interview on 05/14/2024 at 10:44 AM, Staff K stated that Staff P throwing Resident 2 into bed and tucking in their blankets to restrain them was an "everyday situation." Staff K stated they told Staff A and Staff C about it multiple times though nothing was done aside from Staff A talking to Staff P. Staff K stated the first time they heard Staff P say to Resident 2 "this is disgusting" after an episode of bowel incontinence had been in October 2023 or November 2023 of last year. Staff K stated Staff P then refused to help Resident 2 clean up. Staff K stated they told Staff C about the incident.

In an interview on 05/14/2024 at 1:23 PM, Staff A stated they did not know why there was no investigation done for Resident 2's hip injury. Staff A stated they would have considered Resident 2's hip injury an injury of unknown origin if a nurse described it as that but said they themselves had no clinical training. Staff A stated if a nurse thought Resident 2's hip injury was an injury of unknown origin, then an investigation should have been done.

Review of facility records showed no documentation of an investigation for Resident 2's hip injury, or for the alleged physical and verbal abuse by Staff P. The records failed to indicate that the facility instituted appropriate measures to prevent continued abuse of residents or implemented efforts to protect resident during the course of an investigation of abuse by Staff P.

Resident 5

Review of an undated face sheet for Resident 5 showed they had diagnoses including

[redacted], and [redacted].

Review of an employee statement/concern form, dated 01/31/2024, showed Staff F reported to management they felt Staff P neglected Resident 5 by leaving them in soaking wet clothing. The form was signed as received by Staff D the same day.

In an interview on 03/14/2024 at 9:45 AM, Staff E stated Staff F turned in a written grievance on Staff P, about two months ago, because Staff P left Resident 5 in soaking wet clothes for nearly two hours. Staff E stated the grievance was handed directly to Staff D.

In an interview on 05/06/2024 at 12:59 PM, Staff D stated they called Staff A immediately after receiving a grievance from Staff F regarding Staff P's neglect of Resident 5. Staff D stated Staff A directed them to interview the staff who turned in the grievance. Staff D stated they interviewed Staff F then scanned and emailed the grievance and interview responses to Staff A. Staff D stated they felt like Staff F's grievance related to Staff P leaving Resident 5 in wet clothes rose to the level of neglect. Staff D stated they were Staff A's designee. Staff D stated they had concerns about it themselves, though they and Staff A "kind of forgot" about the alleged neglect of Resident 5 because they were focused on Staff P having left the residents in B Cottage with no staff.

In an interview on 04/18/2024 at 5:38 PM, Staff P stated they were never interviewed by Staff A or other management related to allegations of abuse or neglect involving Resident 5.

Review of facility records showed there was no documentation of an investigation for Resident 5's alleged neglect by Staff P. The records failed to indicate that actions were taken to prevent continued neglect by Staff P or to protect the resident from further harm.

In an interview on 03/28/2024 at 11:25 AM, Staff A stated they were new to their role, they did not really understand how to conduct a thorough investigation, they did not understand the Washington Administrative Codes.

This is a recurring deficiency previously cited on 12/28/2022 for subsections (1) (2).

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) 9/5/24 .

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

Administrator (or Representative) — Date 7/11/24

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(b) Verify staff persons' work references prior to hiring;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to verify staff persons' work references prior to hiring for 11 of 11 staff (Staff C, E, F, G, H, I, K, L, M, O, and P). This failure placed residents at risk of receiving inadequate care from potentially unsuitable staff.

Findings included...

Review of a facility document titled, "Pegasus Senior Living Associate Handbook," last revised 12/2022, showed that satisfactory references were a requirement of employment.

Review of undated facility staff rosters showed Staff C, Memory Care Coordinator, was hired on 01/17/2022; Staff E, Medication Technician, was hired on 11/03/2023; Staff F, Care Partner, was hired on 08/01/2023; Staff G, Medication Technician, was hired on 08/08/2023; Staff H, Care Partner, was hired on 02/27/2023; Staff I, Care Partner, was hired on 07/25/2023; Staff K, Care Partner, was hired on 05/06/2023; Staff L, Care Partner, was hired on 07/30/2023; Staff M, Medication Technician, was hired on 02/17/2023; Staff O, Care Partner, was hired on 07/25/2023; and Staff P, Care Partner, was hired on 09/13/2023

In an interview on 03/15/2024 at 9:41 AM, Staff F stated they did not recall the facility checking their references when they were hired.

Observation on 03/15/2024 at 4:48 PM, showed Staff H worked in C Cottage that day.

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

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(b) Verify staff persons' work references prior to hiring;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to verify staff persons' work references prior to hiring for 11 of 11 staff (Staff C, E, F, G, H, I, K, L, M, O, and P). This failure placed residents at risk of receiving inadequate care from potentially unsuitable staff.

Findings included…

Review of a facility document titled, "Pegasus Senior Living Associate Handbook," last revised 12/2022, showed that satisfactory references were a requirement of employment.

Review of undated facility staff rosters showed Staff C, Memory Care Coordinator, was hired on 01/17/2022; Staff E, Medication Technician, was hired on 11/03/2023; Staff F, Care Partner, was hired on 08/01/2023; Staff G, Medication Technician, was hired on 08/08/2023; Staff H, Care Partner, was hired on 02/27/2023; Staff I, Care Partner, was hired on 07/25/2023; Staff K, Care Partner, was hired on 06/06/2023; Staff L, Care Partner, was hired on 07/30/2023; Staff M, Medication Technician, was hired on 02/17/2023; Staff O, Care Partner, was hired on 07/25/2023; and Staff P, Care Partner, was hired on 09/13/2023.

In an interview on 03/15/2024 at 9:41 AM, Staff F stated they did not recall the facility checking their references when they were hired.

Observation on 03/15/2024 at 4:49 PM, showed Staff H worked in C Cottage that day.

In an email communication sent on 03/21/2024 at 2:47 PM, Staff A, Executive Director, stated the facility did not have pre-hire reference checks.

In an interview on 03/22/2024 at 10:14 AM, Staff D, Business Office Manager, stated the facility had not been doing reference checks on new employees.

In an interview on 03/22/2024 at 2:37 PM, Staff L stated they provided the facility with names for reference checks when they were hired, though they did not think the facility ever called their references.

In an interview on 03/22/2024 at 3:53 PM, Staff M stated they provided contact information for reference checks when they were hired, though they never heard from their references that they had been contacted.

The facility provided no documented work references for the Staff C, E, F, G, H, I, K, L, M, O, or P.

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) 8/5/24 .

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

Administrator (or Representative) — Date 7/11/24

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

In an email communication sent on 03/21/2024 at 2:47 PM, Staff A, Executive Director, stated the facility did not have pre-hire reference checks.

In an interview on 03/22/2024 at 10:14 AM, Staff D, Business Office Manager, stated the facility had not been doing reference checks on new employees.

In an interview on 03/22/2024 at 2:37 PM, Staff L stated they provided the facility with names for reference checks when they were hired, though they did not think the facility ever called their references.

In an interview on 03/22/2024 at 3:53 PM, Staff M stated they provided contact information for reference checks when they were hired, though they never heard from their references that they had been contacted.

The facility provided no documented work references for the Staff C, E, F, G, H, I, K, L, M, O, or P.

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

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff reported alleged or suspected abuse and neglect to the Complaint Resolution Unit for 8 of 8 residents (Residents 1, 2, 3, 5, 6, 7, 8, and 9). This failure placed facility residents at increased risk for abuse and neglect by delaying the department's ability to investigate the alleged abuse timely and placed residents at risk for ongoing abuse and neglect.

Findings included…

WAC 388-78A-2020 defines abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult. The WAC states that in instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. The WAC further states that abuse includes mental abuse, physical abuse, personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. The WAC states that physical abuse includes physical mistreatment and mental abuse includes humiliation, harassment, intimidation, ridiculing, swearing, and yelling. The WAC states that improper use of restraint includes physical restraint for convenience or discipline. The WAC defines neglect as a pattern of conduct or inaction resulting in the failure to provide the goods and services that maintain physical or mental health of a resident, or that fails to avoid or prevent physical or mental harm or pain to a resident, The WAC further states that neglect includes an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the residents' health, welfare, or safety.

Per WAC 388-78A-2020 employees of an assisted living facility are defined as mandated reporters.

The facility's policy titled, "Abuse, Neglect and Exploitation," dated 11/2018, stated that in instances of suspected resident abuse, the designated responsible party for the resident, and the appropriate state (department) agency, were to be contacted during the same shift the incident was discovered.

The facility's policy titled, "Reporting of Incidents/Incident Reports," last revised on 05/10/2022, stated that resident related incidents were to be reported to the resident's responsible party and the time and date of notification was to be documented in the incident report. The policy further stated that all incidents related to physical abuse, neglect, sexual assault, or exploitation were to be reported to the ombudsman, state licensing agency, and/or law enforcement per State requirements.

In an interview on 03/15/2024 at 10:04 AM, Staff G, Medication Technician, stated the facility encouraged staff to report concerns to the facility before reporting to the state. Staff G stated they felt staff were discouraged from reporting concerns to state so the facility could deal with concerns on their own.

In an interview on 03/15/2024 at 4:49 PM, Staff H, Care Partner, stated they were told to tell management first if they had an abuse or neglect related concern so management could determine if the staff were “over-reacting” prior to reporting to the state.

In an interview on 03/22/2024 at 2:37 PM, Staff L stated Staff P was not very nice to residents and they witnessed Staff P yell at residents who were hearing impaired, as well as residents who were not. Staff L stated Staff P made residents do things they did not want to do. Staff L stated they heard from other staff that Staff P would grab and restrain residents. Staff L stated one resident cried because they did not want Staff P providing their care. Staff L stated if residents did not do what Staff P wanted, Staff P would yell at them and tell them they had to. Staff L stated they “100% trusted” the reactions the residents had to Staff P, as well as trusted their own instincts about the mistreatment of residents displayed by Staff P. Staff L stated they fully believed the residents’ reactions towards Staff P were warranted. Staff L stated they reported their concerns to management and filled out a grievance form which they put it Staff D’s box about two to three months ago. Staff L stated when they talked to Staff D about their concerns regarding Staff P, they were given the impression Staff D would be calling the state, though they never did. Staff L stated if management felt staff concerns were “stupid”, staff were not listened to.

In an interview on 03/22/2024 at 3:53 PM, Staff M, Medication Technician, stated they knew other staff had concerns about Staff P being abusive towards residents and they were upset because management had not addressed the issues. Staff M stated if they were positive a concern was abuse, they would call the hotline, but if it was questionable, they would just tell management.

In an interview on 03/28/2024 at 11:25 AM, Staff A stated they were new to their role and did not understand the Washington Administrative Codes. Staff A further stated that facility staff did not understand reporting requirements.

In an interview on 05/06/2024 at 12:59 PM, Staff D stated they notified Staff A, Executive Director, of the staff concerns right away and Staff A instructed Staff D on what questions to ask the staff. Staff D stated they interviewed the staff then scanned and emailed the grievances and interview responses to Staff A. Staff D stated they did not report staffs’ concerns to the state themselves because they thought Staff A would have reported them. Staff D stated they were afraid they would be “fired the next day” if they reported an abuse related concern to the state and Staff A or Staff B had not felt it should have been reported.

In an interview on 05/13/2024 at 3:21 PM, Staff E, Medication Technician, stated that they spoke to Staff A on 12/20/2023, 01/11/2024, and 01/25/2024 regarding Staff P ignoring the residents, their motion sensor alarms, forcing them to walk too fast, and leaving the cottages unattended. Staff E stated Staff A’s response was just that they would look into it.

In an interview on 05/14/2024 at 10:44 AM, Staff K, Care Partner, stated that management held a staff in-service where they discussed with staff what did and did not need to be

documented on a grievance. Staff K stated that management reviewed everything that did not need to be put on a grievance and that their list included “just about everything.” Staff K stated that they were told the grievances staff turned in would be reported and that was why Staff K did not report their concerns about Staff P to the state themself. Staff K stated that in official meetings, staff were reminded they were all mandatory reporters, however the rest of the time, staff were reprimanded for reporting concerns.

In an interview on 05/14/2024 at 1:23 PM, Staff A stated that staff were told it was their responsibility to report concerns to the state if management was unavailable.

In an interview on 06/11/2024, Staff A stated that all caregivers received mandatory reporting training during the onboarding process.

Resident 1

In an interview on 03/15/2024 at 10:04 AM, Staff G stated they heard Resident 1 screaming, then witnessed Staff P force the resident to stay in their wheelchair by pulling down on their arms. Staff G stated they notified Staff A immediately.

In an interview on 03/15/2024 at 5:05 PM, Staff A stated that when Staff G notified them they heard Resident 1 yelling “help” while being cared for by Staff P, Staff A spent the rest of the shift in the cottage assisting Staff P provide resident care. Staff A stated they felt Staff P had been “appropriate” with Resident 1 and the incident was not documented or reported.

In an interview on 05/13/2024 at 3:21 PM, Staff E stated in January of 2024 they saw Staff P tipping Resident 1 back in their wheelchair. Staff E stated they told Staff C though management never questioned Staff E about their concern.

In an interview on 05/14/2024 at 10:44 AM, Staff K stated that two times, they saw Staff P go into the bathroom while Resident 1 was in there and abruptly start taking Resident 1’s clothes off then force them into the shower. Staff K stated they told Staff A and Staff B about this concern. When asked what Staff A did about it, Staff K stated that Staff A said, “Well did [Resident 1] get a shower? Then the issue is done.”

In an interview on 05/14/2024 at 1:23 PM, Staff A stated that during the facility investigation of Staff P (initiated after the department’s investigation), Staff S, Care Partner, reported they heard Staff P tell Resident 1 to “sit the f*ck down.” Staff A stated that Staff P denied having said that, so it was just a “he said, she said” situation.

In an interview on 05/16/2024 at 8:46 AM, Staff A stated that Staff G’s report that they

heard Staff P yelling at Resident 1 was not investigated but it should have been. Staff A stated that they would consider a report from staff that another staff was yelling at a resident, to be potential verbal abuse. Staff A stated that the staff should have intervened right away, told the abusive staff to stay away from the resident, and remained with the resident and called for assistance in order to protect the resident.

Review of the department's reporting database showed no facility or facility staff reports related to the alleged physical and verbal abuse of Resident 1 by Staff P.

Resident 2

In an interview on 03/15/2024 at 9:41 AM, Staff F, Care Partner, stated in late October 2023 they witnessed Staff P change Resident 2's brief, and instead of rolling the resident to change them, Staff P lifted their legs up by their head, "like you would change a baby." Staff F stated Resident 2 was found to have a dislocated hip shortly after.

In an interview on 03/25/2024 at 9:42 AM, Staff N, Medication Technician, stated around October 6, 2023, they found something wrong with Resident 2's hip. Staff N stated they notified Staff B that night. Staff N stated Resident 2 was assessed by both hospice and emergency medical technicians and both thought Resident 2's hip was dislocated.

In an interview on 05/13/2024 at 1:37 PM, Staff O stated that at the end of September of 2023, they witnessed Staff P change Resident 2 by lifting their legs up towards their head. Staff O stated they told Staff N then called Staff C, Memory Care Coordinator, immediately. Staff O stated Staff C told them to notify Staff A and Staff B. Staff O stated they left a voicemail for Staff A describing what they saw. Staff O stated Staff N showed Staff P how to properly do pelvic hygiene and talked to Staff P about the risks of changing residents in that manner. Staff O stated they filled out a change in condition form that same shift and turned it into a box near the C Cottage kitchen, though management staff never talked to them about their concern.

In an interview on 05/14/2024 at 8:18 AM, Staff C stated that Staff K told them last fall, before Resident 2 died, that they saw Staff P changing Resident 2 by lifting them from under their legs. Staff C stated they told Staff P that day that that was not how they changed residents at the facility, then educated Staff P on the risks for injury. Staff C stated they explained to Staff P that they did not change residents in the same way you would "change a baby." Staff C stated they told Staff B about the incident. Staff C stated they did not report the concern to the state because they would "hate to speak out of turn" as they were not there to witness the incident.

In an interview on 05/14/2024 at 10:44 AM, Staff K stated that Staff P throwing Resident 2 into bed and tucking in their blankets to restrain them was an "everyday situation." Staff K stated they told Staff A and Staff C about it multiple times though nothing was done aside from Staff A talking to Staff P. Staff K stated that in October or November of 2023, they heard Staff P say to Resident 2 "this is disgusting" after an episode of bowel incontinence.

Staff K stated Staff P then refused to help Resident 2 clean up. Staff K stated they told Staff C about the incident.

In an interview on 05/15/2024 at 12:23 PM, Staff N stated that when Staff O told them how Staff P changed Resident 2, Staff N sent Staff B a picture of Resident 2's hip and that it was "clearly dislocated." Staff N stated Resident 2's dislocated hip could not have been caused by a fall as they were already bedridden by that time.

Review of the department's reporting database showed no facility or facility staff reports related to the alleged physical and verbal abuse of Resident 2 by Staff P.

Resident 3

In an interview on 03/20/2024 at 2:35 PM, Staff K stated they witnessed Staff P yell at Resident 3 in early January 2024. Staff K stated Resident 3 was incontinent, and Staff P told them it was "disgusting," and Resident 3 was "an adult." Staff K stated they told Staff C about Staff P's treatment of Resident 3.

In an interview on 05/06/2024 at 12:59 PM, Staff D stated there was a verbal concern about Staff P last December 2023, prior to the written grievances they received at the end of January. Staff D stated the staff went to Staff A with their concerns, and Staff A asked Staff D to join them in talking to Staff P related to their "tone." Staff D stated they thought Resident 3 was the resident involved. Staff D stated Staff P's explanation was that they spoke loudly to Resident 3 because they thought the resident had difficulty hearing.

In an interview on 05/13/2024 at 3:21 PM, Staff E stated they saw Staff P force Resident 3 to remain at the dining room table during mealtime even when Resident 3 did not want to eat or had not cleared their plate. Staff E stated that Staff P would lock Resident 3's wheelchair brakes and that it occurred in February of 2024.

In an interview on 05/14/2024 at 1:23 PM, Staff A stated that Staff G shared a recording with them of Staff P yelling at Resident 3 around December of 2023. Staff A stated no investigation was done, then said there had been an investigation, though not a formal one. Staff A stated that it was not reported because when they listened to it, they had not felt Staff P was abusive, rather just speaking loudly so Resident 3 could hear them. Staff A stated they felt it was an "internal opportunity for coaching."

In an interview on 05/15/2024 at 11:05 AM, Staff S stated they heard Staff P tell Resident 3 to "sit the f*ck down" last fall. Staff S stated they told Staff C about it at the time, and Staff C had a conversation with Staff P about not talking to the residents like that. Staff S stated they told Staff A about the incident about one and a half months ago, during the facility investigation of Staff P.

In an interview on 05/16/2024 at 8:46 AM, Staff A stated they provided Staff P education related to respect, dignity, and compassion on 12/18/2023, after hearing the recording staff made of Staff P yelling at Resident 3. Staff A stated it was not investigated or reported because they had not felt Staff P was yelling at Resident 3 in an abusive way. When asked why they provided Staff P that kind of education if they had not felt it was abuse, Staff A stated they wanted staff who reported concerns to know their concerns were being addressed by management, that there was a perception that male caregivers were loud, and they wanted to make sure everyone was on the same page. Staff A stated they would “absolutely” consider a staff member telling a memory care resident to “sit the f*ck down” verbal abuse. Staff A stated Staff S told them about Staff P saying that to a resident while Staff S was being questioned during the facility’s investigation of Staff P. Staff A stated the incident was not reported to the state.

Review of the department’s reporting database showed no facility or facility staff reports related to the alleged verbal abuse or restraint of Resident 3 by Staff P.

Resident 5

Review of an employee statement/concern form, dated 01/31/2024, showed Staff F reported to management they felt Staff P neglected Resident 5 by leaving them in soaking wet clothing. The form was signed as received by Staff D the same day.

In an interview on 03/14/2024 at 9:45 AM, Staff E stated Staff P admitted to tipping Resident 5 back in their wheelchair so they couldn’t reach the floor. Staff E stated they spoke with Staff A, Staff B, Staff C, and Staff D about their concerns regarding Staff P but were told the facility did not have enough staff to fire Staff P.

In an interview on 04/01/2024 at 9:07 AM, Staff O stated they witnessed Staff P attempt to change Resident 5 by lifting their legs up by their head. Staff O stated Resident 5 resisted and called Staff P a derogatory term. Staff O stated they told Staff N about the way Staff P tried to change the resident.

In an interview on 05/06/2024 at 12:59 PM, Staff D stated they notified Staff A right away of Staff F’s concern that Staff P had neglected (left in wet clothing) Resident 5. Staff D stated Staff A instructed them on what interview questions to ask, Staff D interviewed staff, then scanned and emailed the grievance form and interview responses to Staff A. Staff D stated they had felt the incident reported by Staff F rose to the level of neglect. Staff D stated they were Staff A’s designee. Staff D stated they had concerns about it themselves, though they and Staff A forgot about the alleged neglect of Resident 5 because they were focused on Staff P having left the residents in B Cottage with no staff.

In an interview on 05/13/2024 at 1:37 PM, Staff O stated they told Staff C and Staff T, Care Partner, about how they saw Staff P change Resident 5, though no one interviewed Staff O about it. Staff O stated they used a shower sheet and an incident report to document the

incident and said they handed it directly to Staff C.

In an interview on 05/14/2024 at 12:23 PM, Staff N stated that when staff told them how Staff P tried to change Resident 5, they would have responded by telling them to write out a statement and tell management. Staff N stated they did not report the incident themselves because they had not seen it occur.

Review of the department's reporting database showed no facility or facility staff reports related to the alleged physical abuse of Resident 5 by Staff P.

Resident 6

In an interview on 03/15/2024 at 9:41 AM, Staff F stated they turned in a grievance on Staff P after seeing them pull on Resident 6's arms.

In an interview on 03/20/2024 at 11:04 AM, Staff I stated they turned in a written grievance to Staff D about a month and a half ago, after witnessing Staff P try to force Resident 6 to shower by pulling on their arms. Staff I stated Staff P told Resident 6 they stunk. Staff I stated they were told to write abuse-related concerns on a grievance form.

In an interview on 05/14/2024 at 8:18 AM, Staff C stated Staff I told them about Staff P pulling on Resident 6's arms to get them to shower a few months ago. Staff C stated Staff A was aware of the allegation because Staff A discussed it with them and with Staff P. Staff C stated that Resident 6 was not the kind of resident who needed hand-in-hand guidance and that Resident 6 was one of the highest functioning memory care residents they had. Staff C stated they did not report the concern to the state because they did not witness the incident.

Review of the department's reporting database showed no facility or facility staff reports related to the alleged verbal and physical abuse of Resident 6 by Staff P.

Resident 7

In an interview on 03/15/2024 at 9:41 AM, Staff F stated Staff P would cause Resident 7 to trip by putting their hand on the resident's back and forcing them to walk faster than they could.

In an interview on 03/22/2024 at 2:37 PM, Staff L stated they witnessed Staff P yell at Resident 7 and pull on them while they were walking. Staff L stated they turned in a written grievance to Staff D about two to three months ago regarding Staff P's treatment of the resident.

In an interview on 05/13/2024 at 9:19 AM, Staff L stated they witnessed Staff P yell at Resident 7 and pull on them while they were walking at the end of November or December of 2023. Staff L stated they reported it verbally to Staff C multiple times, and all Staff C did was say it would be dealt with.

In an interview on 05/13/2024 at 3:21 PM, Staff E stated that around December of 2023, they witnessed Staff P forcing Resident 7 to walk faster than they could, even though Resident 7 verbalized they could not walk that fast. Staff D stated they told Staff C about it and they responded by saying they would talk to Staff P.

Review of the department's reporting database showed no facility or facility staff reports related to the alleged verbal and physical abuse of Resident 7 by Staff P.

Resident 8

In an interview on 03/25/2024 at 9:42 AM, Staff N stated they witnessed Staff P change Resident 8, who had an unrepaired hip fracture, by picking them up from under their knees and pulling their legs up by the resident's head. Staff N stated they turned in a change in condition form related to the incident.

In an interview on 05/15/2024 at 12:23 PM, Staff N stated they told Staff B and Staff C, either the same night or the following morning, that they saw Staff P change Resident 8 by raising their legs towards their head with an unrepaired hip fracture sometime last fall. Staff N stated Staff B and Staff C said they would talk to Staff P. Staff N stated they filled out a change in condition form, then they sent a picture of the form to Staff B, and that they filed the grievance in C Cottage for Staff C. Staff N stated they did not report the incident to the state because they thought management would report it.

Review of the department's reporting database showed no facility or facility staff reports related to the alleged physical abuse of Resident 8 by Staff P.

Resident 9

In an interview on 05/06/2024 at 12:59 PM, Staff D stated that about one and a half weeks ago, they heard Staff A tell Resident 9, a memory care resident who was upset about being kept at the facility and was stating they were going to call the police, that "We are the police" and "this is prison."

In an interview on 05/15/2024 at 11:35 AM, Staff Q, Care Partner, stated they had concerns about an interaction they witnessed between Staff A and Resident 9. Staff Q stated they thought about calling the Ombudsman after the incident though did not call because they were afraid of retaliation. Staff Q stated that Resident 9 was a memory care

Statement of Deficiencies	License #: 2479	Compliance Determination #: 37222
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page of 35	Licensee: PSL Associates, LLC	06/21/2024

resident in A Cottage, they eloped about three weeks ago, and Staff A brought them back to their cottage. Staff Q stated Resident 9 was very agitated that day, so Staff A and Staff B provided the resident one to one supervision after being returned to the cottage. Staff Q stated that when Resident 9 got upset and got louder, so did Staff A. Staff Q stated that Staff A sternly told Resident 9 that "no one was coming to get [Resident 9]" and that "[Resident 9] did not have a home to go back to." Staff Q stated they felt Staff A had been verbally abusive to Resident 9 and that Resident 9 ended up being "ten times more upset" after Staff A's interactions with them. Staff Q stated that Resident 9 got physically aggressive with Staff A that day. Staff Q stated they did not feel that Staff A knew how to talk to memory care residents.

In an interview on 05/18/2024 at 8:46 AM, Staff A stated they would consider a staff member telling a memory care resident that the staff were the police, and the memory care was a prison, a form of verbal abuse.

Review of the department's reporting database showed no facility or facility staff reports related to the alleged verbal abuse of Resident 9 by Staff 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) 8/5/24.

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

Administrator (or Representative) — Date: 7/11/24

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

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

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

(3) Not use restraints on any resident;

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to promote residents' rights during staffs' provision of care for 6 of 9 residents (Residents 1, 2, 3, 5, 6, 7, 8, and 9). These

resident in A Cottage, they eloped about three weeks ago, and Staff A brought them back to their cottage. Staff Q stated Resident 9 was very agitated that day, so Staff A and Staff B provided the resident one to one supervision after being returned to the cottage. Staff Q stated that when Resident 9 got upset and got louder, so did Staff A. Staff Q stated that Staff A sternly told Resident 9 that “no one was coming to get [Resident 9]” and that “[Resident 9] did not have a home to go back to.” Staff Q stated they felt Staff A had been verbally abusive to Resident 9 and that Resident 9 ended up being “ten times more upset” after Staff A’s interactions with them. Staff Q stated that Resident 9 got physically aggressive with Staff A that day. Staff Q stated they did not feel that Staff A knew how to talk to memory care residents.

In an interview on 05/16/2024 at 8:46 AM, Staff A stated they would consider a staff member telling a memory care resident that the staff were the police, and the memory care was a prison, a form of verbal abuse.

Review of the department’s reporting database showed no facility or facility staff reports related to the alleged verbal abuse of Resident 9 by Staff 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)_____ .

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

_____ _____

Administrator (or Representative) Date

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

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

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

(3) Not use restraints on any resident;

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to promote residents’ rights during staffs’ provision of care for 8 of 9 residents (Residents 1, 2, 3, 5, 6, 7, 8, and 9). These

failures resulted in Resident 1 being physically restrained by staff, Residents 2, 6 and 8 being subjected to alleged physical abuse by staff, Residents 3 and 9 being subjected to alleged verbal abuse by staff, Resident 5 being subjected to alleged physical abuse and neglect by staff, and Resident 7 being subjected to alleged physical and verbal abuse by staff. Additionally, these failures placed facility residents at increased risk for physical injury, psychosocial harm, and decreased quality of life.

Findings included…

WAC 388-78A-2020 defines abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult. The WAC states that in instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. The WAC further states that abuse includes mental abuse, physical abuse, personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. The WAC states that physical abuse includes physical mistreatment and mental abuse includes humiliation, harassment, intimidation, ridiculing, swearing, and yelling. The WAC states that improper use of restraint includes physical restraint for convenience or discipline. The WAC defines neglect as a pattern of conduct or inaction resulting in the failure to provide the goods and services that maintain physical or mental health of a resident, or that fails to avoid or prevent physical or mental harm or pain to a resident, The WAC further states that neglect includes an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the residents' health, welfare, or safety.

The facility's policy titled, "Resident Rights," last revised on 12/2023, stated all residents of the community were accorded resident rights as mandated by state regulations and as outlined in the residency agreement documents.

The facility's policy titled, "Abuse, Neglect and Exploitation," dated 11/2018, stated that abuse involved physical, verbal, financial and/or psychological punishment of a resident and/or involved willful misconduct, and/or involved harm or injury as a direct result of the abuse.

Review of the facility's undated characteristic roster showed eight of nine A Cottage residents had dementia (a group of conditions characterized by impairment of memory and judgement), Alzheimer's (a progressive disease that destroys memory and other mental function), or other cognitive impairments. The characteristic roster showed that all six residents in B Cottage and all 11 residents in C Cottage had dementia, Alzheimer's, or other cognitive impairments. The characteristic roster showed that 13 of the facility's 67 assisted living residents had dementia, Alzheimer's, or other cognitive impairments.

In an interview on 03/14/2023 at 9:45 AM, Staff E, Medication Technician, stated Staff P, Care Partner, forced residents to do things they did not want to do. Staff E stated staff had

concerns about Staff P pushing residents too fast in their wheelchairs and ignoring residents when they talked to Staff P. Staff E stated you could see that the residents' reactions to Staff P were not good, and that it was a "red flag." Staff E stated they brought up their concerns about Staff P to Staff A, Executive Director, Staff B, Health and Wellness Specialist, and Staff C, Memory Care Coordinator. Staff E stated Staff C told them it was not their job to worry about it.

In an interview on 03/15/2024 at 9:41 AM, Staff F, Care Partner, stated Staff P was way too rough with the residents. Staff F stated Staff P just sat on the couch or in the kitchen their whole shift, they were very slow to respond to emergencies, and they were never out with the residents. Staff F stated Staff P was too impatient to tell the residents what they were doing. Staff F stated Staff P "bullied" residents on a regular basis and they had no people skills. Staff F stated they were certain management was aware of the concerns about Staff P because so many staff had complained. Staff F stated management moved Staff P to assisted living but did nothing else to address staff concerns. Staff F stated Staff P often worked in the memory care cottages by themselves. Staff F stated they knew other staff had turned in grievances about Staff P also.

In an interview on 03/15/2024 at 5:05 PM, Staff A stated they received a report that Staff P was verbally aggressive to a resident.

In an interview on 03/25/2024 at 9:42 AM, Staff N, Medication Technician, stated they heard repeatedly from care staff that Staff P yelled at residents, Staff P was testy, and Staff P snapped at residents. Staff N stated Staff P often ignored the motion alarms which resulted in resident falls. Staff N stated Staff P would often be found in the cottage kitchens with the doors closed, even though Staff N told them to keep the doors open so they could hear the motion sensor alarms.

In an interview on 05/06/2024 at 12:59 PM, Staff D stated they were staff A's designee.

In an interview on 05/14/2024 at 1:23 PM, Staff A stated they recalled hearing that Staff P had been lifting a resident by their legs to provide pelvic hygiene, but Staff A could not remember who the resident was.

In an interview on 05/15/2024 at 12:23 PM, Staff N stated the reports from staff that Staff P yelled at residents, was testy, snappy, and that Staff P ignored the residents' alarms started a couple of weeks to a month after Staff P started working at the facility last September. Staff N stated that Staff A met with Staff P in B Cottage to address concerns about Staff P' treatment of the residents. The conversation occurred before the initiation of the state's investigation (which was initiated on 02/22/2024), and while Staff P was still working in both memory care and assisted living.

Resident 1

Review of an undated face sheet for Resident 1 showed they were 73 years old.

Review of a negotiated service agreement (NSA) for Resident 1, dated 01/09/2024, showed they had diagnoses including [redacted], and [redacted]. The NSA showed they were alert to self only, they were unable to state their age or date of birth, they did not know the time, the date, their location, or that they required supervision. The NSA stated Resident 1 was to be re-directed without escalation of behavior and if they refused care, staff were to attempt at a later time. The NSA showed staff were to use a calm reassuring voice, validate the resident's feelings, and not argue with them.

In an interview on 03/11/2024 at 10:16 AM, Collateral Contact 1 (CC1), Resident Representative, stated about three weeks prior, a staff member told them they witnessed Staff P shove Resident 1 into their wheelchair. CC1 stated the staff member reported the incident to Staff A immediately.

In an interview on 03/14/2023 at 9:34 AM, Staff E stated they witnessed Staff P tilt Resident 1 back in their wheelchair until the front wheels were off the floor so Resident 1 would be unable to reach the floor with their feet to stop Staff P from pushing them.

In an interview on 03/15/2024 at 9:41 AM, Staff F stated they witnessed Staff P bear hug Resident 1 to restrain them in order to get them changed.

In an interview on 03/15/2024 at 10:04 AM, Staff G, Medication Technician, stated they witnessed Staff P force Resident 1 to remain in their wheelchair by pulling the resident's arms down. Staff G stated they notified Staff A immediately and Staff A came to Resident 1's cottage and spent the remainder of the shift with Staff P.
In an interview on 03/16/2024 at 8:14 AM, Staff A denied awareness of concerns involving Staff P shoving Resident 1 into their chair though said Staff G had notified them about Staff P being verbally aggressive.

In an interview on 03/20/2024 at 2:35 PM, Staff K, Care Partner, stated Staff P would force Resident 1 to shower, and at other times Staff P would document Resident 1 refused when no shower was offered. Staff K stated Staff P caused Resident 1 to go into panic attacks and Resident 1 would react angrily towards Staff P. Staff K stated Staff P would often get Resident 1 so upset they would swing at Staff P, and the situation would result in disciplinary action for Resident 1. Staff K stated Staff P often worked in Resident 1's cottage alone.

In an interview on 03/28/2024 at 9:31 AM, Staff K stated they could see physical reactions of fear from the residents when they saw Staff P.

In an interview on 04/01/2024 at 9:07 AM, Staff O, Care Partner, stated they saw Staff P "fully yelling" at three residents, including Resident 1. Staff O stated Resident 1 was not

hearing impaired. Staff O stated Staff P worked alone in Resident 1's cottage often.

In an interview on 04/18/2024 at 5:38 PM, Staff P stated people assumed they were physically abusive to residents. Staff P stated Resident 1 "walked like they were in a drunken stupor." Staff P stated Resident 1 would sometimes yell for help when Staff P "helped them to their seat." Staff P stated the first time they were suspended pending allegations of resident abuse was in mid-March of 2024.

In an interview on 05/13/2024 at 1:37 PM, Staff O stated they witnessed Staff P yelling at residents between September of 2023 to April 0f 2024, when Staff P had to provide incontinence care, shower the residents, or bring them down for meals.

In an interview on 05/13/2024 at 3:21 PM, Staff E stated it was in January of 2024 when they witnessed Staff P tipping Resident 1 back in their wheelchair. Staff E stated they notified Staff C about it the following day and Staff C's response was stating they would talk to Staff P about it. Staff E stated no one talked to them any further about their concern. Staff E stated that they spoke to Staff A on 12/20/2023, 01/11/2024, and 01/25/2024 regarding Staff P ignoring the residents, their motion sensor alarms, forcing them to walk too fast, and leaving the cottages unattended. Staff E stated Staff A's response was that they would look into it.

In an interview on 05/14/2024 at 10:44 AM, Staff K stated that Staff P regularly documented that Resident 1 had refused showers when no shower was offered. Staff K stated at other times, Staff P would go into the bathroom while Resident 1 was in there, start taking Resident 1's clothes off, then force them into the shower. Staff K stated they saw this twice but could not recall when. Staff K stated they told Staff A and Staff B about it and Staff A responded by stating, "Well did [Resident 1] get a shower? Then the issue is done."

In an interview on 05/14/2024 at 1:23 PM, Staff A stated that Staff S, Care Partner, reported they heard Staff P tell Resident 1 to "sit the f*ck down." Staff A stated that Staff P denied having said that, so it was just a "he said, she said" situation.

In an interview on 05/16/2024 at 8:46 AM, Staff A stated that Staff P was not suspended following Staff G's report that they heard Staff P yelling at Resident 1. Staff A stated the incident was not investigated but it should have been. Staff A stated that they did consider a report from staff that another staff was yelling at a resident, to be potential verbal abuse.

Resident 2

Review of an undated face sheet for Resident 2, showed they were 80 years old and had a diagnosis of [redacted].

Review of a progress note for Resident 2, dated 09/27/2023, showed the resident was not oriented enough to take their medications and they were seen by hospice that day.

Review of a progress note for Resident 2, dated 09/28/2023, showed all Resident 2's non-comfort related medications were discontinued that day.

Review of a progress note for Resident 2, dated 10/05/2023, showed the resident's representative was thinking of moving Resident 2 home for end of life care.

Review of a progress note for Resident 2, dated 10/06/2023, showed they were lying in bed with their mouth open, their eyes slightly open, and their mouth was dry. The note stated Resident 2 did not respond to verbal stimuli, oral care, or face shaving performed by staff.

Review of a progress note for Resident 2, dated 10/07/2023 at 8:50 AM, showed a hospice nurse came to assess the resident's hip. The note stated 911 was being called for a second opinion.

Review of an incident note for Resident 2, with an effective date of 10/08/2023 at 12:01 AM, and written by Staff B, showed the hospice nurse felt Resident 2's left hip may have been dislocated because it appeared more protruded than their right hip. The incident note showed Resident 2's right leg was contracted (deformed) but their left leg was straight. The incident note showed Staff B observed swelling to Resident 2's left hip and the area was firm. The incident note showed emergency medical technicians assessed Resident 2's left hip and they also determined something was wrong.

Review of a progress note for Resident 2, dated 10/08/2023 at 7:13 AM, showed when care staff repositioned the resident, they showed signs of pain, including wincing and groaning. The note further showed that morphine (narcotic pain medication) was being administered every two hours so staff could move and reposition Resident 2 without causing pain. The note showed Resident 2's eyes opened when staff entered their room and when spoken to, Resident 2's eyes filled with "water".

In a progress note for Resident 2, dated 10/08/2023 at 1:18 PM, staff documented Resident 2 was observed to no longer be breathing, and they had no pulse or breath sounds. The note showed hospice pronounced Resident 2's death at 3:14 PM.

In an interview on 03/20/2024 at 2:35 PM, Staff K stated they witnessed Staff P "throw" Resident 2 into bed. Staff K stated Staff P would restrain Resident 2 with their own blankets. Staff K stated they thought that was a big reason for Resident 2's falls. Staff K stated Staff P often worked in Resident 2's cottage alone.

In an interview on 03/28/2024 at 9:16 AM, Staff F stated Resident 2 was nearly non-verbal by the time Staff P changed them by placing their legs up by their head, before the resident's death last fall. Staff F stated Resident 2 groaned and tensed up when being turned.

In an interview on 03/28/2024 at 9:31 AM, Staff K stated they trained Staff P during the week prior to Resident 2's death. Staff K stated they witnessed Staff P loop their arm under Resident 2's knees, lifting their hips off the bed, "every chance they got." Staff K stated Staff P would then remove their arm from beneath the resident's knees and use their hand to push Resident 2's legs all the way back by their head in order to wipe them, and again to place the brief beneath them. Staff K stated Resident 2 was not speaking much by that point though they would respond by trying to punch Staff P and grab Staff P's clothes. Staff K stated Staff P would change Resident 2 in that manner while they were sleeping, without waking the resident. Staff K stated Resident 2 would pull their blankets up as high as they could and hold them down to avoid being changed by Staff P. Staff K stated the way Staff P changed Resident 2 "would take the human out of someone." Staff K stated they told Staff B how they saw Staff P change Resident 2. Staff K stated Staff P provided Resident 2's care during the days leading up to Resident 2's death.

In an interview on 04/01/2024 at 9:07 AM, Staff O stated they witnessed Staff P change Resident 2 by pulling their legs up by their head, just before the resident was found the have a dislocated hip then died. Staff O stated Resident 2 had been declining and was "out of it." Staff O stated Resident 2 winced and called Staff P a "son of a b*tch," and that Resident 2 did not speak much after that. Staff O stated the incident was very degrading to Resident 2. In an interview on 04/18/2024 at 5:38 PM, Staff P stated they remembered lifting Resident 2 by the knees. Staff P stated Resident 2 would "prevent you" from rolling them by grabbing the edges of the bed and sticking their feet out, which Staff P referred to as "the starfish." Staff P stated other residents were "cognitive enough to refuse," though Resident 2 was not. Staff P stated the first time they were suspended pending allegations of resident abuse was in mid-March of 2024.

In an interview on 05/13/2024 at 1:37 PM, Staff O stated it was the end of September of 2023 when they witnessed Staff P change Resident 2 by lifting their legs towards their head. Staff O stated they told Staff A and Staff C about their concerns involving Staff P's treatment of residents in September or October of last year.

In an interview on 05/14/2024 at 8:18 AM, Staff C, Memory Care Coordinator, stated that Staff K told them last fall, before Resident 2 died, that they saw Staff P changing Resident 2 by lifting them from under their legs. Staff C stated they told Staff P that day that that was not how they changed residents at the facility. Staff C stated they explained to Staff P that they did not change residents in the same way you would "change a baby." Staff C stated they told Staff B about the incident.

In an interview on 05/14/2024 at 10:44 AM, Staff K stated they witnessed Staff P throw Resident 2 into bed and restrain them with their blankets on a daily basis. Staff K stated they told Staff C and Staff A about it multiple times though nothing was ever done aside from Staff A talking to Staff P. Staff K stated they also heard Staff P say to Resident 2 "this

is disgusting" after an episode of bowel incontinence in October or November of last 2023. Staff K stated Staff P then refused to help Resident 2 clean up.

In an interview on 05/14/2024 at 1:23 PM, Staff A stated they did not know why there was no investigation done for Resident 2's hip injury. Staff A stated they would have considered Resident 2's hip injury an injury of unknown origin if a nurse would have described it that way. Staff A stated if a nurse thought Resident 2's hip injury was an injury of unknown origin, then an investigation should have been done.

Review of a facility staff schedule showed Staff P worked the evening shifts in Resident 2's cottage on 10/01/2023, 10/02/2023, 10/03/2023, 10/04/2023, and 10/05/2023.

Resident 3

Review of an undated face sheet for Resident 3, showed they were 97 years old and had diagnoses including [redacted] and [redacted].

In an interview on 03/20/2024 at 2:35 PM, Staff K stated in early January of 2024, Resident 3 was incontinent of bowel and Staff P yelled at them and made them feel "sub-par to human" by saying things like "this is disgusting," and "you're an adult." Staff K stated Staff P also yelled at Resident 3 to stay in bed. Staff K stated Staff P often worked in Resident 3's cottage alone.

In an interview on 03/28/2024 at 9:31 AM, Staff K stated Resident 3 thought Staff P was a not a good caregiver. Staff K stated Resident 3 would get in their wheelchair and go the opposite direction of Staff P.

In an interview on 04/01/2024 at 9:07 AM, Staff O stated they saw Staff P yell at three residents, including Resident 3. Staff O stated Resident 3 was the only one of the three residents who was hearing impaired, and as long as you spoke clearly, you did not have to raise your voice for Resident 3 to hear you. Staff O stated Staff P often worked in Resident 3's cottage alone. Staff O stated they told Staff C and Staff A about their concerns involving Staff P's treatment of residents in September or October of 2023.

In an interview on 04/18/2024 at 5:38 PM, Staff P stated the first time they were suspended pending allegations of resident abuse was in mid-March of 2024.

In an interview on 05/06/2024 at 12:59 PM, Staff D stated there was a verbal concern about Staff P last December, prior to the written grievances they received at the end of January. Staff D stated the staff went to Staff A with their concerns, and Staff A asked Staff D to join them in talking to Staff P related to their "tone." Staff D stated they thought Resident 3 was the resident involved. Staff D stated Staff P's explanation was that they just spoke loudly to Resident 3 because they were hard of hearing.

In an interview on 05/13/2024 at 3:21 PM, Staff E stated they saw Staff P force Resident 3 to remain at the dining room table during mealtime even when Resident 3 did not want to eat or had not cleared their plate. Staff E stated that Staff P would lock Resident 3's wheelchair brakes and that it occurred in February of 2024.

In an interview on 05/14/2024 at 8:18 AM, Staff C stated that when they listened to Staff G's recording, they heard Resident 3 say "I can't hear you." Staff C stated they notified Staff A and Staff B but did not report the incident to the state themselves because they thought Staff P was just raising their voice to be heard so no abuse occurred. Staff C stated Staff A responded by saying they would talk to Staff P about it.

In an interview on 05/14/2024 at 10:44 AM, Staff K stated the first time they heard Staff P tell Resident 3 their bowel incontinence was "disgusting" was in October or November of 2023. Staff K stated Staff P refused to help Resident 3 clean up. Staff K stated they told Staff C.

In an interview on 05/14/2024 at 1:23 PM, Staff A stated that Staff G shared a recording with them of Staff P yelling at Resident 3 around December of last year. Staff A stated no investigation was done, then said there had been an investigation, though not a formal one. Staff A stated that it was not reported because when they listened to it, they had not felt Staff P was abusive, rather just speaking loudly so Resident 3 could hear them. Staff A stated they felt it was an "internal opportunity for coaching."

In an interview on 05/15/2024 at 11:05 AM, Staff S, Care Partner, stated they heard Staff P tell Resident 3 to "sit the f*ck down" last fall. Staff S stated they told Staff C about it at the time, and Staff C had a conversation with Staff P about not talking to the residents like that. Staff S stated they were not aware the facility had grievance forms at the time. Staff S stated they told Staff A about the incident about one and a half months ago, during the facility investigation of Staff P.

In an interview on 05/16/2024 at 8:46 AM, Staff A stated they provided Staff P education related to respect, dignity, and compassion on 12/18/2024, after hearing the recording staff made of Staff P yelling at Resident 3. Staff A stated it was not investigated or reported because they had not felt Staff P was yelling at Resident 3 in an abusive way. When asked why they provided Staff P that kind of education if they had not felt it was abuse, Staff A stated they wanted staff who reported concerns to know their concerns were being addressed by management, that there was a perception that male caregivers were loud, and they wanted to make sure everyone was on the same page. Staff A stated they would "absolutely" consider a staff member telling a memory care resident to "sit the f*ck down" verbal abuse. Staff A stated Staff S told them about Staff P saying that to a resident while Staff S was being questioned during the facility's investigation of Staff P.

Resident 5

Review of an undated face sheet for Resident 5, showed they were 89 years old and had diagnoses including [redacted], and [redacted].

Review of an NSA for Resident 5, dated 02/04/2024, showed they were alert and oriented to self and family on an appropriate and consistent basis, they were able to recall their date of birth and age, and they could recognize other residents and staff they had frequent interactions with.

Review of an employee statement/concern form, dated 01/31/2024, showed Staff F reported to management they felt Staff P neglected Resident 5 by leaving them in soaking wet clothing. The form was signed as received by Staff D the same day.

In an interview on 03/11/2024 at 3:55 PM, Collateral Contact 5 (CC5), Resident Representative, stated Resident 5's two thousand dollar oxygen concentrator went missing from the resident's closet. CC5 stated they notified Staff B about the missing concentrator about two months ago. CC5 stated the concentrator was never found and Resident 5 was never reimbursed.

In an interview on 03/14/2024 at 9:45 AM, Staff E stated Staff P admitted to tipping Resident 5 back in their wheelchair so they couldn't reach the floor. Staff E stated Resident 5 called Staff P a derogatory term. Staff E stated Resident 5 referred to Staff P as "that *sshole". Staff E stated they spoke with Staff A, Staff B, Staff C, and Staff D about their concerns regarding Staff P but were told the facility did not have enough staff to fire Staff P.

In an interview on 03/20/2024 at 2:35 PM, Staff K stated Staff P often worked in Resident 5's cottage alone.

In an interview on 03/28/2024 at 9:31 AM, Staff K stated Resident 5 always requested that someone besides Staff P change them.

In an interview on 04/01/2024 at 9:07 AM, Staff O stated they witnessed Staff P raise Resident 5's legs up by their head to change them, and the resident resisted and called Staff P a "dumb*ss," then asked Staff P where they were trained. Staff O stated the incident was very degrading to Resident 5. Staff O stated Staff P worked alone in Resident 5's cottage often. Staff O stated they told management about their concerns involving Staff P's treatment of residents in September or October of last year.

In an interview on 04/18/2024 at 5:38 PM, Staff P stated the first time they were suspended pending allegations of resident abuse was in mid-March of 2024.

In an interview on 05/06/2024 at 12:59 PM, Staff D stated they notified Staff A right away

of Staff F's concern that Staff P had left Resident 5 in wet clothing. Staff D further stated they had felt the incident reported by Staff F rose to the level of neglect.

In an interview on 05/13/2024 at 1:37 PM, Staff O stated it was during an evening shift last fall that they witnessed Staff P raise Resident 5's legs up by their head to change them. Staff O stated they told Staff C and Staff T, Care Partner, about it immediately. Staff O stated they filled out a shower sheet and an incident report and they handed it directly to Staff C, though no one ever interviewed Staff O about their concerns.

In an interview on 05/13/2024 at 3:21 PM, Staff E stated it was in January of 2023 that Staff P told them they tipped Resident 5 back in their wheelchair all the time. Staff E stated they told Staff C about it the following day, and that Staff C's response was stating they would talk to Staff P about it.

In an interview on 05/14/2024 at 12:23 PM, Staff N stated that when staff told them how Staff P tried to change Resident 5, they would have responded by telling them to write out a statement and tell management. Staff N stated they did not report the incident themselves because they had not seen it occur.

Resident 6

Review of an undated face sheet for Resident 6, showed they were 75 years old and had diagnoses of [redacted] and [redacted].

In an interview on 03/15/2024 at 9:41 AM, Staff F stated they witnessed Staff P trying to force Resident 6 to take a shower when they did not want to. Staff F stated Staff P removed the pillows from behind the resident's back, pulled on their arms to force them up, and told Resident 6, "We can do this all day." Staff F stated they turned in a written grievance to management related to Staff P's mistreatment of Resident 6 though no management staff ever talked to them about their concern.

In an interview on 03/20/2024 at 11:04 AM, Staff I, Care Partner, stated that about one and a half months ago, when Staff P was forcing Resident 6 to shower by pulling on their arms, Resident 6 sighed, became frustrated, and became agitated. Staff I stated they turned in a grievance form about Staff P's mistreatment of Resident 6 to the file outside of Staff D's office. Staff I stated Staff D talked to them about their concern and stated they told Staff D they felt frustrated and upset because Staff P was physically forcing Resident 6 to do something they did not want to do.

In an interview on 03/20/2024 at 2:35 PM, Staff K stated Staff P often worked in Resident 6's cottage alone.

In an interview on 04/01/2024 at 9:07 AM, Staff O stated they saw Staff P "fully yelling" at

three residents, including Resident 6. Staff O stated Resident 6 was not hearing impaired. Staff O stated that in September or October of last year, they told Staff C about Staff P's mistreatment of the residents, and Staff C responded with disbelief. Staff O stated they then went to Staff A with their concerns, and Staff A told Staff O it was not their place to worry about what other staff were doing.

In an interview on 04/18/2024 at 5:38 PM, Staff P stated Resident 6 only needed prompting for showers, not physical assistance. Staff P stated you had to "fight psychologically" with Resident 6 to get them to shower. Staff P stated the first time they were suspended pending allegations of resident abuse was in mid-March of 2024.

In an interview on 05/14/2024 at 8:18 AM, Staff C stated Staff I told them about Staff P pulling on Resident 6's arms to get them to shower a few months ago. Staff C stated Staff A was aware of the allegation because Staff A discussed it with them and with Staff P. Staff C stated that Resident 6 was not the kind of resident who needed hand-in-hand guidance and that Resident 6 was one of the highest functioning memory care residents they had.

Resident 7

Review of an undated face sheet for Resident 7, showed they were 99 years old and they had macular degeneration (an eye disease that causes vision loss).
In an interview on 03/15/2024 at 9:41 AM, Staff F stated Staff P would put their hand on Resident 7's back while they were walking, forcing the resident to walk faster than they could, causing them to "trip up."

In an interview on 04/01/2024 at 10:28 AM, Collateral Contact 3, Resident Representative, stated Resident 7 did not need help when walking and they used their walker independently.

In an interview on 04/18/2024 at 5:38 PM, Staff P stated Resident 7 was able to walk independently with their walker. Staff P stated the first time they were suspended pending allegations of resident abuse was in mid-March of 2024.

In an interview on 05/13/2024 at 9:19 AM, Staff L stated they witnessed Staff P yell at Resident 7 and pull on them while they were walking at the end of November or December of 2023. Staff L stated they reported it verbally to Staff C multiple times and all Staff C did was say it would be dealt with.

In an interview on 05/13/2024 at 3:21 PM, Staff E stated they witnessed Staff P forcing Resident 7 to walk faster than they could, even though Resident 7 verbalized they could not walk that fast, around December of 2023. Staff D stated they told Staff C about it, and they responded by saying they would talk to Staff P.

Resident 8

Review of an undated face sheet for Resident 8 showed they were 100 years old and had diagnoses including [redacted], and [redacted].

Review of a facility investigation for Resident 8, dated 11/14/2023, showed they had a fall that morning resulting in a femur fracture.

In an interview on 03/25/2024 at 9:42 AM, Staff N stated Resident 8 fell last fall, resulting in a fractured hip. Staff N stated no surgical repair was done and Resident 8 returned to the facility on hospice care. Staff N stated shortly after the resident's return to the facility, they witnessed Staff P pick Resident 8's legs up under the resident's knees and pull their legs up by the resident's head in order to change them. Staff N stated they told Staff B and Staff C what they saw Staff P do.

In an interview on 04/18/2024 at 2:52 PM, Collateral Contact 7, Resident Representative, stated Resident 8 died about nine days after their fall in November.

In an interview on 04/18/2024 at 5:38 PM, Staff P stated the first time they were suspended pending allegations of resident abuse was in mid-March of 2024.

Resident 9

In an interview on 05/06/2024 at 12:59 PM, Staff D stated that about one and a half weeks ago, they heard Staff A tell Resident 9, a memory care resident who was upset about being kept at the facility and was stating they were going to call the police, that "We are the police and this is prison."

In an interview on 05/15/2024 at 11:35 AM, Staff Q, Care Partner, stated they had concerns about an interaction they witnessed between Staff A and Resident 9. Staff Q stated that Resident 9 was a memory care resident, they eloped about three weeks ago, and Staff A was the one to bring them back to their cottage. Staff Q stated Resident 9 was very agitated that day, so Staff A and Staff B provided the resident one to one supervision after being returned to the cottage. Staff Q stated that when Resident 9 got upset and got louder, so did Staff A. Staff Q stated that Staff A argued with Resident 9. Staff Q stated that Staff A sternly told Resident 9 that no one was coming to get them, and that the resident did not have a home to go back to." Staff Q stated they felt Staff A had been verbally abusive to Resident 9 and that Resident 9 ended up being "ten times more upset" after Staff A's interactions with them. Staff Q stated they did not feel that Staff A knew how to talk to memory care residents.

In an interview on 05/16/2024 at 8:46 AM, when asked if they would consider a staff

member telling a memory care resident that the staff were the police and the memory care was a prison, a form of verbal abuse, Staff A said they would.

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) 8/5/24 .

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

Administrator (or Representative) — Date: 7/11/24

WAC 388-78A-2600 Policies and procedures.

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

(r) When receiving and responding to resident grievances consistent with RCW 70.129.060 , and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to adhere to their grievance policy for 1 of 1 staff (Staff A) following receipt of three documented resident care concerns. This failure placed Resident 5 at increased risk for inadequate care, physical and psychosocial harm, and decreased quality of life. Additionally, this failure placed B Cottage residents at risk for physical harm, psychosocial harm, and elopement due to inadequate supervision by staff.

Findings included...

The facility's policy titled, "Grievance Policy," dated 03/01/2022, stated the Executive Director and the Regional Vice President of Operations were responsible for ensuring prompt efforts were made to resolve grievances. The policy stated the administrative team was responsible for receiving and tracking all grievances through to their conclusion, including leading any necessary investigations. The policy stated the Executive Director was to maintain a log of grievances/complaints to include the date and time of the grievance, the employee who received the grievance, a description of the complaint/issue, and the resolution/follow up

member telling a memory care resident that the staff were the police and the memory care was a prison, a form of verbal abuse, Staff A said they would.

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

WAC 388-78A-2600 Policies and procedures.

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

(r) When receiving and responding to resident grievances consistent with RCW 70.129.060 ; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to adhere to their grievance policy for 1 of 1 staff (Staff A) following receipt of three documented resident care concerns. This failure placed Resident 5 at increased risk for inadequate care, physical and psychosocial harm, and decreased quality of life. Additionally, this failure placed B Cottage residents at risk for physical harm, psychosocial harm, and elopement due to inadequate supervision by staff.

Findings included…

The facility's policy titled, "Grievance Policy," dated 03/01/2022, stated the Executive Director and the Regional Vice President of Operations were responsible for ensuring prompt efforts were made to resolve grievances. The policy stated the administrative team was responsible for receiving and tracking all grievances through to their conclusion, including leading any necessary investigations. The policy stated the Executive Director was to maintain a log of grievances/complaints to include the date and time of the grievance, the employee who received the grievance, a description of the complaint/issue, and the resolution/follow up.

Review of an employee statement/concern form, dated 01/31/2024, showed Staff I, Care Partner, observed Staff P, Care Partner, leave the memory care residents in B Cottage unattended on 01/31/2024. The form showed Staff I was concerned for resident safety because B Cottage residents were at high risk for falls. The form showed Staff L, Care Partner, also witnessed Staff P leave the residents unattended. The form was initialed as received by Staff D, Business Office Manager, on 01/31/2024, indicating facility management was aware of the unsupervised memory care residents. The grievance form failed to indicate how the grievance was resolved.

Review of an employee statement/concern form, dated 01/31/2024, showed that on 01/31/2024 at 8:50 AM, Staff L witnessed Staff P leave a memory care cottage while no other staff were present, leaving the residents in the cottage by themselves. The form showed the incident was witnessed by two other staff, including Staff I. The form was initialed as received by Staff D on 01/31/2024, indicating facility management was aware of the unsupervised memory care residents. The grievance form failed to indicate how the grievance was resolved.

In an interview on 03/14/2024 at 9:34 AM, Staff E, Medication Technician, stated Staff A, Executive Director, had the “final say” in how grievances were addressed.

In an interview on 03/14/2024 at 11:02 AM, Staff C, Memory Care Coordinator, stated the facility used grievance forms that went to Staff A.

In an interview on 03/15/2024 at 2:44 PM, Staff A stated all grievances came to them and grievances were kept in a log, even after a concern had been resolved.

In an interview on 03/15/2024 at 5:05 PM, Staff A stated they never received written grievances regarding Staff P.

In an interview on 03/20/2024 at 11:47 AM, Staff J, Resident Care Coordinator, stated resident care concerns were often ignored by management.

In an interview on 03/20/2024 at 2:35 PM, Staff K, Care Partner, stated staff were told they were writing too many grievances, they were told to stop writing them, and the grievance slips were removed my management from the memory care.

In an interview on 03/22/2024 at 10:14 AM, Staff D stated they worked with Staff A on staff grievances. Staff D stated they could not recall if the facility received any written concerns from staff about Staff P’s treatment of residents. When told multiple staff members reported turning in multiple written grievances directly to Staff D, Staff D then recalled receiving them around late December or early January, and that management determined it had been an issue with the concerned staffs’ “perceptions.” Staff D stated they believed the written concerns came from three Care Partners, Staff F, L, and I.

In an interview on 03/28/2024 at 9:31 AM, Staff K stated the facility took the grievance forms out of the cottages because staff were reporting too many concerns. Staff K stated staff started documenting their abuse and neglect related concerns on change of condition forms.

In an interview on 05/06/2024 at 12:59 PM, Staff D stated they called Staff A immediately after receiving the grievances from Staff L and Staff I stating Staff P left the memory care residents unattended, and the grievance from Staff F stating Staff P left Resident 5 in wet clothes. Staff D stated Staff A directed them to interview Staff L and Staff I. Staff D stated they interviewed Staff L and Staff I then scanned and emailed the grievance and interview responses to Staff A. Staff D stated they did not ask Staff L or Staff I how long Staff P was out of the cottage.

In an interview on 05/13/2024 at 11:01 AM, Staff J stated staff were told to put resident and staff concerns on change of condition forms, that they were filed in the residents' charts, and that Staff B, Health and Wellness Specialist, would removed them from the residents' charts when annual surveys started.

Resident 5

Review of an undated face sheet for Resident 5, showed they had chronic pain, anxiety disorder, and depression.

Review of an employee statement/concern form, dated 01/31/2024, showed Staff F reported to management they felt Staff P neglected Resident 5 by leaving them in soaking wet clothing. The grievance form failed to indicate how the grievance was resolved.

In an interview on 05/06/2024 at 12:59 PM, Staff D stated they notified Staff A right away of Staff F's concern that Staff P had neglected Resident 5. Staff D interviewed staff, then scanned and emailed the grievance form and interview responses to Staff A. Staff D stated they (Staff D) had felt the incident reported by Staff F rose to the level of neglect. Staff D stated they had concerns about it themselves, though they and Staff A "kind of forgot" about the alleged neglect of Resident 5.

Statement of Deficiencies	License #: 2479	Compliance Determination #37222
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page of 35	Licensee: PSL Associates, LLC	06/21/2024

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) 8/5/24.

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

Administrator (or Representative) — Date: 7/11/24

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