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) 51011 (Completion Date 12/02/2024) and 46418 (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-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

The Department staff who did the On Site verification:
Carla Rose, NCI Community Licensor
Patricia Eddy, Community Licensor

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

Sincerely,

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

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, 09/09/2024, 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) Date

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure medications were administered as prescribed for 2 of 9 residents (Residents 1 and 4). This failure resulted in missed medication, contributed to increased discomfort for Resident 1 and placed them at risk for a decline in health.

Findings included…

<Resident 1>

Review of a Negotiated Service Plan (the facility's titled negotiated service agreement, NSA) for Resident 1, dated [redacted]/2024, showed the resident was admitted to the facility on [redacted]/2024.The NSA showed that Resident 1 required physical assistance of two staff during showers twice a week, one staff to assist to shampoo and dry the resident's hair. Further review showed that Resident 1 required assistance with medication administration.

Review of Resident 1's August 2024 Treatment Administration Record showed an order for ketoconazole shampoo (used to treat fungal infections of the scalp), apply to scalp two times per week on Wednesday and Sunday. Further review showed the ketoconazole was not given on:

08/04/2024 (Sunday) 9:00 AM with the reason documented as "out of time frame."
08/14/2024 (Wednesday) 9:00 AM with the reason documented as "not shower day."
08/18/2024 (Sunday) 9:00 AM with the reason documented as "did not receive

shower."
08/21/2024 (Wednesday) 9:00 AM with the reason documented as "moved to pm."
08/25/2024 (Sunday) 6:00 PM with the reason documented as "Patient unable to take medication."

Observation on 08/28/2024 at 2:40 PM showed Resident 1 had large patches of grey and white scales of skin around their hairline on their forehead, above the right ear and right temporal area, and a noticeable amount of small white flakes diffused across the upper shoulders and chest area of their dark blue shirt. Resident 1 stated in an interview at that time, that their head had been itching.

Observation on 08/29/2024 at 2:00 PM showed Resident 1's scalp had large patches of grey and white scales of skin to areas of their scalp along the hairline and above and behind their right ear .

In an interview on 08/29/2024 at 1:50 PM, Staff C, Resident Care Coordinator, stated that Resident 1 preferred to take their showers in the evening so they had moved the administration time that the shampoo was scheduled to be given, from the day shift to the evening shift on 08/21/2024. When asked what days the resident was scheduled to receive their shower and why the resident hadn't received the medication, Staff C stated they did not know.

Observation on 08/30/2024 at 2:15 PM showed Resident 1's ketoconazole medicated shampoo with a label dated [redacted]/2024 had a red seal of tape over the cap which showed it had not been opened or used.

<Resident 4>

Review of Resident 4's NSA, dated 06/23/2024, showed the resident required assistance with medication administration.

Review of Resident 4's August 2024 Medication Administration Record (MAR) showed an order for a pilocarpine tablet (used to treat dry mouth) to be given twice a day. Further review showed the resident did not receive either dose on August 1, 2024. The MAR documented the medication was not available at those times.

In an interview on 09/18/2024 at 1:35 PM, Staff B, Health and Wellness Specialist, stated the pilocarpine medication was not given due to not being ordered from the pharmacy in time.

This is an uncorrected deficiency previously cited on 06/04/2024 and a recurring deficiency previously cited on 09/06/2023.

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

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: 121849
Compliance Determination #: 38532
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 03/19/2024 through 06/04/2024
Complainant Contact Date(s): 03/20/2024, 06/04/2024

Allegation(s):

1. Resident did not receive requested suppository resulting in ER trip for rectal bleeding.
2. Fall.
3. Resident missing meals.
4. Staffing.

Investigation Methods:

Sample:
Total residents: 101
Resident sample size: 4
Closed records sample size: 0

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

Interviews:
Reporter
Executive Director
Health and Wellness Specialist
Alleged Victim
Alleged Victim's Representative
Residents

Record Reviews:
-Disclosure of Services
-Characteristic roster
-Staff roster
-Resident face sheets
-Resident care plans
-Progress notes
-Hospital after visit summaries
-Fall Policy
-Incident investigations

-Medication administration records
-Monitoring documentation
-Medication Services Policy

Investigation Summary:

1. The Alleged Victim was care planned for assistance with medications. Review of the Alleged Victim's medication administration record showed the resident's medications were not administered as ordered. Failed facility practice identified and cited under WAC 388-78A-2210 Medication Services (2) (a). This is a recurring citation previously cited on 09/06/2023.
2. The Alleged Victim was sent to the hospital for medical care. Appropriate parties were notified, and an investigation was completed. Review of the Alleged Victim's care plan showed that it reflected their risk for falls and included interventions to prevent reoccurrence. Interview with the Alleged Victim's Representative showed that changes were made to allow the resident to obtain assistance at night more easily. Staff were observed available to assist with resident care needs. No failed facility practice.
3. Assisted living residents were interviewed and they voiced no food related concerns. Document review showed that the Alleged Victim refused meals at times, and that their attendance to meals and intake were being monitored. The Alleged Victim was observed and they appeared well-nourished. Staff were observed actively preparing for dinner service. No failed facility practice.
4. Residents interviewed voiced no concerns related to facility staffing levels. The Alleged Victim was observed and no unmet needs were identified. Staff were observed working in all three memory care cottages and the assisted living building. They were available to assist with resident care needs. No failed facility practice.

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

Statement of Deficiencies	License #: 2479	Compliance Determination #38532
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 1 of 4	Licensee: PSL Associates, LLC	06/04/2024

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 complaint investigation on 03/19/2024, 03/19/2024 and 03/19/2024 of:

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

This document references the following complaint number(s): 122777, 121849, 121087, 121080

The following sample was selected for review during the unannounced on-site visit: 4 of 101 current residents and 0 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: 06/12/2024

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

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Statement of Deficiencies	License #: 2479	Compliance Determination # 38532
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 2 of 4	Licensee: PSL Associates, LLC	06/04/2024

Administrator (or Representative) 6/12/24 Date

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2260 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed ensure prescribed medication was administered as ordered for 1 of 1 residents (Resident 1). This failure resulted in missed medications and contributed to an increase in discomfort requiring a trip to the emergency room which involved multiple invasive medical procedures for Resident 1. This failure placed facility residents who required assistance with medication at risk for health complications, inadequate symptom management, and decreased quality of life.

Findings included...

The facility's policy titled, "Medication Services Policy," dated 11/2018, stated that each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living community will provide medication assistance, must receive their medications as prescribed.

Review of Resident 1's face sheet, dated 07/06/2023, showed that the resident was iron deficient and had gastrointestinal (digestive system pathway) disorders.

Review of Resident 1's negotiated service agreement (NSA), dated 10/28/2023, showed that Resident 1 required assistance with medications. The NSA showed that a licensed nurse or medication technician was responsible for assisting Resident 1 with their medications according to doctor's orders.

Review of a hospital after visit summary for Resident 1, dated 03/05/2024, showed the resident was seen for lower gastrointestinal (GI) bleeding that day, the resident had an intravenous catheter (IV) for fluid replacement, they underwent multiple imaging studies, had multiple labs drawn, and were referred to a gastroenterologist (gastrointestinal medical specialist) for further care

Administrator (or Representative) Date

WAC 388-78A-2210 Medication services.

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Findings included…

The facility's policy titled, "Medication Services Policy," dated 11/2018, stated that each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living community will provide medication assistance, must receive their medications as prescribed.

Review of Resident 1's face sheet, dated 07/06/2023, showed that the resident was iron deficient and had gastrointestinal (digestive system pathway) disorders.

Review of Resident 1's negotiated service agreement (NSA), dated 10/28/2023, showed that Resident 1 required assistance with medications. The NSA showed that a licensed nurse or medication technician was responsible for assisting Resident 1 with their medications according to doctor's orders.

Review of a hospital after visit summary for Resident 1, dated 03/05/2024, showed the resident was seen for lower gastrointestinal (GI) bleeding that day, the resident had an intravenous catheter (IV) for fluid replacement, they underwent multiple imaging studies, had multiple labs drawn, and were referred to a gastroenterologist (gastrointestinal medical specialist) for further care.

Review of Resident 1's medication administration records (MARs) for February 2024 and March of 2024, showed that Resident 1 was prescribed a rectal suppository to treat hemorrhoids (swollen and inflamed veins at the end of the digestive tract that cause discomfort and bleeding) on 02/16/2024. The order was for one suppository at bedtime for seven days. On 02/17/2024 and 02/18/2024, Staff A, Medication Technician, documented they had not administered the suppositories on those dates because they were "waiting on delivery from pharmacy." The MARs showed that Resident 1 never received this scheduled medication. Further review of the MARs showed Resident 1 also had an order for the rectal suppositories to be given every 12 hours as needed. The as needed order was also received on 02/16/2024. The MARs showed that the first time Resident 1 received a suppository was on 03/06/2024 (nearly three weeks after it was initially ordered and after Resident 1 went to the emergency room for GI bleeding). The staff who administered the suppository, Staff A, documented that the suppository was effective.

Review of a progress note for Resident 1, written by Staff B, Health and Wellness Specialist, with an effective date of 03/07/2024 at 1:49 AM, showed that Staff B spoke with Collateral Contact 1 (CC1), Resident Representative, on 03/06/2024, and that CC1 filled out a nurse delegation form so staff could be delegated to administer Resident 1's suppositories (nearly three weeks after the suppositories were ordered).

In an interview on 03/19/2024 at 3:40 PM, CC1 stated that Resident 1 required suppositories for severe hemorrhoids at times, and that their hemorrhoids caused discomfort. CC1 stated Resident 1 had an order for the suppositories since 02/16/2024. CC1 stated that on 03/03/2024, Resident 1 told them they were having rectal bleeding. CC1 stated they had Resident 1 ask the medication technician on duty for a suppository mid-morning that day, though Resident 1 was told there was no order for the suppositories. CC1 stated that on 03/04/2024, they called Staff B and asked them to go check on Resident 1 and give them a suppository. CC1 stated Staff B confirmed there was an order for the suppository and said they would examine Resident 1 and administer the suppository if needed, though that did not happen on that day. CC1 stated that on 03/05/2024, Resident 1 reported feeling light-headed and nauseous. CC1 stated that Resident 1 called their primary care physician, told them they had been bleeding for three days, and Resident 1 was directed to go to the emergency room. CC1 stated that Resident 1 went to the emergency room, and while there, they did blood work, imaging studies, and an examination. CC1 stated Staff B told them they would look into why the staff told Resident 1 there was no order for the suppositories.

This is a recurring citation previously cited on 09/06/2023.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2479	Compliance Determination # 38532
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 4 of 4	Licensee: PSL Associates, LLC	08/04/2024

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) 7/19/24 .

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

Administrator (or Representative) — Date: 6/12/24

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