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

11/26/2024

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) 50923 (Completion Date 11/26/2024) and 46419 (Completion Date 10/04/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/26/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(c) Provide residents, families, and other visitors with a means to contact a staff person inside the building from outside the building after hours.

(2) The assisted living facility must provide one or more nonpay telephones:

(a) In each building located for ready access for staff persons; and

(b) On the premises with reasonable access and privacy by residents.

The Department staff who did the On Site verification:

Carla Rose, NCI 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

10/16/2024
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.

Administrator (or Representative) Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure care and services, listed in the negotiated services agreement, were implemented for 1 of 2 residents (Resident 1). This failure resulted in decreased showers and contributed to skin break down for the resident and placed the resident at increased risk for compromised skin integrity and infection.

Findings included…
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 on [redacted]/2024 and had diagnoses of [redacted] ([redacted]), [redacted] ([redacted]) [redacted] ([redacted]) and [redacted] ([redacted]). Further review of the NSA showed that Resident 1 required physical assistance of two staff during showers twice a week, with one staff to assist to shampoo and dry the resident's hair. The NSA showed staff were to use pillows to float/position the resident's heels off of the mattress when the resident was laid in bed to prevent pressure sores to the heels.

<Showers>

In an interview on 08/27/2024 at 11:21 AM, Staff E, Medication Aide, stated that they had been concerned about Resident 1 not getting showered as scheduled since their admission on [redacted]/2024.

Review of Resident 1's shower flow sheet for August 2024 showed that the resident received a shower twice in the month of August, on 08/11/2024 and 08/18/2024.

<Heels>

Observation on 08/28/2024 at 2:45 PM, showed Resident 1 laid in bed. Resident 1's right heel laid directly on the mattress as the resident laid on their left side. Further observation showed Staff D, Care Partner, removed the resident's sock and a quarter sized reddened area was noted to be on the resident's inner left side of the right heel (the area that had laid directly on the mattress).

In an interview on 08/29/2024 at 11:45 AM, Staff B, Health and Wellness Specialist, stated they had observed Resident 1's pressure sore on their heel.

Observation on 08/29/2024 at 2:00 PM showed Resident 1 laid in their bed on their left side with both feet laying directly on the mattress with no pillow underneath their feet or either heel.

This is an uncorrected deficiency previously cited on 06/14/2024 and recurring deficiency previously cited on 02/09/2024.

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-2930 Communication system.

(1) The assisted living facility must:

(c) Provide residents, families, and other visitors with a means to contact a staff person inside the building from outside the building after hours.

(2) The assisted living facility must provide one or more nonpay telephones:

(a) In each building located for ready access for staff persons; and

(b) On the premises with reasonable access and privacy by residents.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure there was a consistently operational telephone available for communication between residents, family, and staff for 12 of 12 residents (Residents 2, 3, 5, 6, 11, 12, 13, 14, 15, 16, 17, 18). This failure inhibited communication between residents, families, and staff, and placed A cottage residents at risk for psychosocial harm, delay in treatment, and decreased quality of life.

Findings included...

Review of an undated facility characteristic roster showed that Residents 2, 3, 5, 6, 11, 12, 13, 14, 15, 16, 17, 18 resided in the facility's A Cottage.

In an interview on 08/26/2024 at 4:00 PM, Staff A, Executive Director, stated the facility had purchased phones for staff to use in the cottages that were not internet service based. Staff A stated when a resident received a phone call at the main building, then call staff in the cottages on the staff's phone to notify them a phone call had come in for a resident, and then transferred the call. Staff A stated that when the staff member received the call, they would then transfer it to the resident's portable phone. Staff A further stated that the residents' portable phone in each cottage was still internet based and the quality of the call was dependent on the internet connectivity. When asked if any resident family members had complained recently about phone service to residents, Staff A, stated yes, and identified that Resident 2's family had.

In an interview on 08/26/2024 at 12:55 PM, Resident 2 stated the resident portable phone had never worked well, it would cut off or hang up during phone calls, and that they hadn't talked to family on the resident portable phone for many months. Resident 2 stated that the resident portable phone worked so poorly that their friend bought them a phone to use, but at that time the resident didn't know where it was located.

In an interview on 08/27/2024 at 1:40 PM, Collateral Contact 1 (CC1), Resident Representative, stated they could not call Resident 2's cottage to speak to Resident 2 or the staff. CC1 stated they had not been able to reach Resident 2 on the phone for over seven months. CC1 stated they had recently encouraged a family member to call Resident 2 due to the resident feeling ill. CC1 reported that after five unsuccessful attempts, neither they or Resident 2's family member were able to reach the resident on the phone.

Observation on 08/27/2024 at 1:06 PM, showed when a call was placed by the department licensor to the main facility phone number, the call was answered and when the department licensor requested to speak with Resident 2, in A Cottage, the phone

call was placed on hold, then transferred and there was a busy signal until the line disconnected. The call was not completed.

In an observation on 08/27/2024 at 1:34 PM, showed when a call was placed to the main facility phone number, the call was answered and when the department licensor requested to speak with Resident 2 in A Cottage, the phone call was placed on hold, then transferred and there was a busy signal until the line disconnected. The call was not completed.

In an interview on 08/27/2024 at 2:20 PM, Staff J, Care Partner, stated they have had issues with resident phone calls in A Cottage frequently, and B Cottage at times intermittently. Observation at that time, of A Cottage phone, showed it displayed a red circle with a black line and it was set to “do not disturb.” Further observation showed 54 missed calls.

In an interview on 08/28/2024 at 2:50 PM, Staff V, Care Partner, stated that the cottages continued to have issues with phone calls: the calls drop, cut out or they can’t hear what is being said. Staff V further stated whenever they need to call a family member or the pharmacy, they use a landline phone in the cottage office (a room not accessible to residents due to confidential information being visible) because they were the only reliable phones available to use for important calls.

This is an uncorrected deficiency previously cited on 06/14/2024.

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

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: 124909
Compliance Determination #: 39636
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 04/11/2024 through 06/14/2024
Complainant Contact Date(s):

Allegation(s):
Physician's orders not being followed.

Investigation Methods:

Sample:
Total residents: 103
Resident sample size: 2
Closed records sample size: 1

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

Interviews:
Executive Director
Health and Wellness Specialist
Alleged Victim
Care Partner
Resident Representative
Resident
Alleged Victim's Representative

Record Reviews:
-Disclosure of Services
-Characteristic roster
-Staff roster
-Resident face sheets
-Resident care plans
-Medication administration records
-Provider orders
-Communication System Policy
-Incident investigation
-Progress notes
-Medication Assistance Policy
-Staff schedule
-After visit summary

Investigation Summary:

The Alleged Victim's care plan indicated that staff were to apply compression wraps to the resident's legs daily. Document review showed the wraps were not initiated at the time they were added to the resident's plan of care. Failed practice identified and cited under WAC 388-78A-2160 Implementation of negotiated service agreement.

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: 124907
Compliance Determination #: 39636
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 04/11/2024 through 06/14/2024
Complainant Contact Date(s):

Allegation(s):

1. Staffing.
2. Insufficient cleaning and care supplies.
3. Unreliable communication system for memory care cottages.

Investigation Methods:

Sample:	Total residents: 103 Resident sample size: 2 Closed records sample size: 1
Observations:	Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Executive Director Health and Wellness Specialist Residents Care Partner Resident Representatives
Record Reviews:	-Disclosure of Services -Characteristic roster -Staff roster -Resident face sheets -Resident care plans -Medication administration records -Provider orders -Communication System Policy -Incident investigation -Progress notes -Medication Assistance Policy -Staff schedule -After visit summary

Investigation Summary:

1. Interviews with facility staff and residents showed there continued to be shifts where only one care staff was available to assist with resident care in the memory care cottages. Failed facility practice identified under WAC 388-78A-2450 Staff (1)(a). Facility already out of compliance as of 06/11/2024.
2. Staff interviewed reported that care and cleaning supplies were available when needed. Residents interviewed voiced no concerns related to inadequate facility-supplied care and cleaning products. Observation of facility bathrooms and laundry areas showed supplies were available. No failed facility practice.
3. The facility failed to ensure that consistently functioning telephones were available for resident, staff, and family communication. Failed practice identified and cited under WAC 388-78A-2930 Communication system (1)(c)(2)(a)(b).

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: 123857
Compliance Determination #: 39636
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 04/11/2024 through 06/14/2024
Complainant Contact Date(s):

Allegation(s):
Injuries of unknown origin.

Investigation Methods:

Sample:
Total residents: 103
Resident sample size: 2
Closed records sample size: 1

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

Interviews:
Executive Director
Health and Wellness Specialist
Residents
Care Partner
Alleged Victim's Representative
Resident Representative

Record Reviews:
-Disclosure of Services
-Characteristic roster
-Staff roster
-Resident face sheets
-Resident care plans
-Medication administration records
-Provider orders
-Communication System Policy
-Incident investigation
-Progress notes
-Medication Assistance Policy
-Staff schedule
-After visit summary

Investigation Summary:

The Alleged Victim's Representative reported that the resident's injuries were due to a fall. The facility was requested to provide a fall investigation for the Alleged Victim and no investigation was provided. The Alleged Victim's injuries were observed prior to the facility's stated time of occurrence. Failed practice identified under WAC 388-78A-2371 Investigations (1)(2)(3). Facility already out of compliance as of 06/11/2024.

Conclusion / Action:

- ☐ Failed Provider Practice Identified / Citation(s) Written
- ☒ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A

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

Statement of Deficiencies	License #: 2479	Compliance Determination #39536
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 1 of 4	Licensee: PSL Associates, LLC	06/14/2024

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 04/11/2024, 04/11/2024 and 05/06/2024 of:

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

This document references the following complaint number(s): 124909, 124907, 123857

The following sample was selected for review during the unannounced on-site visit: 2 of 103 current residents and 1 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: 06/25/2024

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

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 04/11/2024, 04/11/2024 and 05/06/2024 of:

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

This document references the following complaint number(s): 124909, 124907, 123857

The following sample was selected for review during the unannounced on-site visit: 2 of 103 current residents and 1 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 # 39836
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 2 of 4	Licensee: PSL Associates, LLC	06/14/2024

Administrator (or Representative) — Date: 7/1/24

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure physician ordered treatments, listed in the resident's negotiated service agreement, were implemented for 1 of 1 resident (Resident 1). This failure resulted in swelling, difficulty with activities of daily living, and a decreased quality of life and placed the resident at increased risk for compromised skin integrity, infection, and other health complications.

Findings included...

Review of a negotiated service agreement (NSA) for Resident 1, dated 12/21/2023, showed the resident had congestive heart failure (a chronic disease that causes swelling in the legs, ankles, and feet). Further review of the care plan identified that Resident 1 was to wear compression wraps daily, and they were to be applied and removed by the medication technician.

Review of a medication administration record (MAR) for Resident 1, dated January 2024, showed that the physician's order for bilateral lower extremity wraps was not added to the resident's MAR, to instruct care staff to apply them, until 01/19/2024, nearly one month after they were added to Resident 1's NSA.

In an interview on 04/11/2024 at 12:39 pm, Resident 1 stated it took them a year to get the facility to wrap their legs. Resident 1 stated they usually asked the medication technician to wrap their legs, and they usually sent a care staff to do it or said they would come back but did not. Resident 1 stated they only got their legs wrapped two to three times a week. Resident 1 stated that staff always blamed the other shifts.

In an interview on 06/13/2024 at 9:05 AM, Collateral Contact 1 (CC1), Resident Representative, stated staff did not begin wrapping Resident 1's legs until January of 2024. CC1 stated that Resident 1's legs were very swollen and painful when not wrapped. CC1 stated that Resident 1 was often unable to get their shoes on because of the swelling in their feet, and that Resident 1 had a hard enough time walking even with shoes on.

Administrator (or Representative) Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure physician ordered treatments, listed in the resident's negotiated service agreement, were implemented for 1 of 1 resident (Resident 1). This failure resulted in swelling, difficulty with activities of daily living, and a decreased quality of life and placed the resident at increased risk for compromised skin integrity, infection, and other health complications.

Findings included…

Review of a negotiated service agreement (NSA) for Resident 1, dated 12/21/2023, showed the resident had congestive heart failure (a chronic disease that causes swelling in the legs, ankles, and feet). Further review of the care plan identified that Resident 1 was to wear compression wraps daily, and they were to be applied and removed by the medication technician.

Review of a medication administration record (MAR) for Resident 1, dated January 2024, showed that the physician's order for bilateral lower extremity wraps was not added to the resident's MAR, to instruct care staff to apply them, until 01/19/2024, nearly one month after they were added to Resident 1's NSA.

In an interview on 04/11/2024 at 12:39 pm, Resident 1 stated it took them a year to get the facility to wrap their legs. Resident 1 stated they usually asked the medication technician to wrap their legs, and they usually sent a care staff to do it or said they would come back but did not. Resident 1 stated they only got their legs wrapped two to three times a week. Resident 1 stated that staff always blamed the other shifts.

In an interview on 06/13/2024 at 9:05 AM, Collateral Contact 1 (CC1), Resident Representative, stated staff did not begin wrapping Resident 1's legs until January of 2024. CC1 stated that Resident 1's legs were very swollen and painful when not wrapped. CC1 stated that Resident 1 was often unable to get their shoes on because of the swelling in their feet, and that Resident 1 had a hard enough time walking even with shoes on.

Statement of Deficiencies	License # 2479	Compliance Determination # 338636
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 3 of 4	Licensee: PSL Associates, LLC	06/14/2024

In an interview on 06/21/2024 at 1:46 PM, Staff B, Health and Wellness Specialist, stated that upon admittance to the facility, Resident 1's care plan included instructions for caregivers to apply wraps to the resident's legs. Staff B further stated they had observed swelling to the resident's lower legs.

This is a recurring deficiency previously cited on 02/08/2024.

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) 7/29/24.

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

Administrator (or Representative) — Date: 7/1/24

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(c) Provide residents, families, and other visitors with a means to contact a staff person inside the building from outside the building after hours.

(2) The assisted living facility must provide one or more nonpay telephones:

(a) In each building located for ready access for staff persons; and

(b) On the premises with reasonable access and privacy by residents.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure there was a consistently operational telephone available for communication between residents, family, and staff for 12 of 12 residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12). This failure inhibited communication between residents, families, and staff, and placed A cottage residents at risk for psychosocial harm, delay in treatment, and decreased quality of life.

Findings included...

Review of an undated facility characteristic roster showed that Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12 resided in the facility's A Cottage.

In an interview on 06/21/2024 at 1:45 PM, Staff B, Health and Wellness Specialist, stated that upon admittance to the facility, Resident 1's care plan included instructions for caregivers to apply wraps to the resident's legs. Staff B further stated they had observed swelling to the resident's lower legs.

This is a recurring deficiency previously cited on 02/09/2024.

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-2930 Communication system.

(1) The assisted living facility must:

(c) Provide residents, families, and other visitors with a means to contact a staff person inside the building from outside the building after hours.

(2) The assisted living facility must provide one or more nonpay telephones:

(a) In each building located for ready access for staff persons; and

(b) On the premises with reasonable access and privacy by residents.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure there was a consistently operational telephone available for communication between residents, family, and staff for 12 of 12 residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12). This failure inhibited communication between residents, families, and staff, and placed A cottage residents at risk for psychosocial harm, delay in treatment, and decreased quality of life.

Findings included…

Review of an undated facility characteristic roster showed that Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12 resided in the facility's A Cottage.

Statement of Deficiencies	License #: 2479	Compliance Determination #:38636
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 4 of 4	Licensee: PSL Associates, LLC	06/14/2024

In an interview on 04/11/2024 at 11:40 AM, Staff A, Executive Director, stated the facility used internet phones and that calls dropped sometimes. Staff A stated the issue had been going on for at least seven months or longer. Staff A further stated that the staff radios were staticky at times.

In an interview on 06/13/2024 at 9:05 AM, Collateral Contact 1 (CC1), Resident Representative, stated they could not call Resident 1's cottage to talk to Resident 1 or the staff. CC1 stated that when they called the main building and the staff tried to transfer the call to Resident 1's cottage, the line was always either busy or they got a "deadline signal." CC1 stated they had to call back multiple times, and that the only way they were able to talk to Resident 1 or the cottage staff was by leaving a message and having the staff call CC1 back from their personal cell phones. CC1 stated there was no phone number that they could use to reach Resident 1's cottage without leaving a message and waiting for someone to call them back.

In an observation on 06/14/2024 at 2:56 PM, a call was placed to the main facility phone number. The call was unanswered, option number nine was entered (for the concierge), and a recorded voice stated the caller had reached the Executive Director's voicemail.

In an observation on 06/14/2024 at 3:36 PM, a call was placed to the main facility phone number. The call was answered by a staff member who stated they would transfer the call to A Cottage as requested. The phone rang until 3:37 PM, then a "beep, beep, beep, beep," was heard for approximately ten seconds, then the call was disconnected. This investigator was unable to reach any A Cottage residents or staff.

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) 7/29/24.

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

Administrator (or Representative) — Date: 7/1/24

In an interview on 04/11/2024 at 11:40 AM, Staff A, Executive Director, stated the facility used internet phones and that calls dropped sometimes. Staff A stated the issue had been going on for at least seven months or longer. Staff A further stated that the staff radios were staticky at times.

In an interview on 06/13/2024 at 9:05 AM, Collateral Contact 1 (CC1), Resident Representative, stated they could not call Resident 1's cottage to talk to Resident 1 or the staff. CC1 stated that when they called the main building and the staff tried to transfer the call to Resident 1's cottage, the line was always either busy or they got a "deadline signal." CC1 stated they had to call back multiple times, and that the only way they were able to talk to Resident 1 or the cottage staff was by leaving a message and having the staff call CC1 back from their personal cell phones. CC1 stated there was no phone number that they could use to reach Resident 1's cottage without leaving a message and waiting for someone to call them back.

In an observation on 06/14/2024 at 2:56 PM, a call was placed to the main facility phone number. The call was unanswered, option number nine was entered (for the concierge), and a recorded voice stated the caller had reached the Executive Director's voicemail.

In an observation on 06/14/2024 at 3:36 PM, a call was placed to the main facility phone number. The call was answered by a staff member who stated they would transfer the call to A Cottage as requested. The phone rang until 3:37 PM, then a "beep, beep, beep, beep," was heard for approximately ten seconds, then the call was disconnected. This Investigator was unable to reach any A Cottage residents or staff.

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