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) 50968 (Completion Date 11/26/2024) and 46420 (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-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(5) Appropriate behavioral interventions, if needed;

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

WAC 388-78A-3140 Responsibilities during inspections. The assisted living facility must:

(2) Provide requested records to the representatives of the department; and

The Department staff who did the On Site verification:

Brian Zbylski, ALF Licensor
Jennifer Lee, Assisted Living Facility 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 # 45420
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 1 of 8	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, 09/09/2024, 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 Piggras, 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

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

Statement of Deficiencies	License #: 2479	Compliance Determination # 46420
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 2 of 8	Licensee: FSL Associates, LLC	10/04/2024

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.

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

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that behavioral interventions were included in the negotiated service agreement for 1 of 1 resident (Resident 4). This failure placed Resident 4 at increased risk for food borne illness and an unhygienic environment.

Findings included...

Observation on 08/29/2024 at 10:42 AM, showed Resident 4 was in the dining room eating their breakfast with six bananas sitting on the table and two bananas in Resident 4's walker basket used to carry personal items. Observation showed all the bananas were very brown and wrinkled. In an interview at that time, Resident 4 stated they had received the bananas from the kitchen staff. Resident 4 stated they had requested to take the bananas since the staff stated they had been set aside to be thrown away. Resident 4 stated that the bananas would last much longer in their refrigerator and didn't need to be thrown away.

In an interview on 08/30/2024 at 10:00 AM, Staff C, Resident Care Coordinator, stated they had heard from facility staff that Resident 4 was in a manic state, as they had been observed with food that was not edible in their refrigerator and they had been aware the resident often refused to let staff clean out expired food from their refrigerator.

Review of Resident 4's Negotiated Service Plan (the facility's titled negotiated service agreement, NSA), dated 06/23/2024, showed a diagnoses of [redacted]. Further review showed no behavioral interventions for Resident 4's behavior of refusing staff assistance with checking for and throwing out expired food.

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-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that behavioral interventions were included in the negotiated service agreement for 1 of 1 resident (Resident 4). This failure placed Resident 4 at increased risk for food borne illness and an unhygienic environment.

Findings included...

Observation on 08/29/2024 at 10:42 AM, showed Resident 4 was in the dining room eating their breakfast with six bananas sitting on the table and two bananas in Resident 4's walker basket used to carry personal items. Observation showed all the bananas were very brown and wrinkled. In an interview at that time, Resident 4 stated they had received the bananas from the kitchen staff. Resident 4 stated they had requested to take the bananas since the staff stated they had been set aside to be thrown away. Resident 4 stated that the bananas would last much longer in their refrigerator and didn't need to be thrown away.

In an interview on 08/30/2024 at 10:00 AM, Staff C, Resident Care Coordinator, stated they had heard from facility staff that Resident 4 was in a manic state, as they had been observed with food that was not edible in their refrigerator and they had been aware the resident often refused to let staff clean out expired food from their refrigerator.

Review of Resident 4's Negotiated Service Plan (the facility's titled negotiated service agreement, NSA), dated 06/23/2024, showed a diagnosis of [redacted] ([redacted]). Further review showed no behavioral interventions for Resident 4's behavior of refusing staff assistance with checking for and throwing out expired food.

In an interview on 09/19/2024 at 1:30 PM, Staff B, Health and Wellness Specialist, stated Resident 4 had been keeping expired food in their refrigerator and refusing to let staff clean it out for three to four months and acknowledged that the behavior was not listed on Resident 4's NSA.

This is an uncorrected deficiency previously cited on 07/03/2024.

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-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure prescribed medications were obtained in a timely manner for 2 of 8 residents (Resident 1 and 20) sampled for medication services. This failure resulted in the residents not receiving their medications as prescribed and placed the residents at risk for a health complications.

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 on [redacted]/2024 and was diagnosed with [redacted]. Further review showed that Resident 1 required facility assistance with medications.

Review of Resident 1's August 2024 and September 2024 medication administration records (MARs) showed an order for an eye vitamin. Further review showed that from

In an interview on 09/18/2024 at 1:30 PM, Staff B, Health and Wellness Specialist, stated Resident 4 had been keeping expired food in their refrigerator and refusing to let staff clean it out for three to four months and acknowledged that the behavior was not listed on Resident 4's NSA.

This is an uncorrected deficiency previously cited on 07/03/2024.

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-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure prescribed medications were obtained in a timely manner for 2 of 9 residents (Resident 1 and 20) sampled for medication services. This failure resulted in the residents not receiving their medications as prescribed and placed the residents at risk for a health complications.

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 on [redacted]/2024 and was diagnosed with [redacted] ([redacted]). Further review showed that Resident 1 required facility assistance with medications.

Review of Resident 1's August 2024 and September 2024 medication administration records (MARs) showed an order for an eye vitamin. Further review showed that from

08/16/2024 through the morning dose on 09/08/2024 AM, the resident's eye vitamins were not administered.

In an interview on 08/28/2024 at 2:45 PM, Staff V, Care Partner, stated when Resident 1 was admitted to the facility, they had a order for the eye vitamin. Staff V stated the eye vitamin was not available in the facility, so the Resident's family brought in medication, but it did not match the doctor's prescription. Staff V further stated that there were still no eye vitamins on hand that could be given as ordered.

In an interview 09/18/2024, Staff B, Health and Wellness Specialist, stated they obtained an order on [redacted]/2024 (36 days after the resident admitted) to give the eye medication that the family had brought in on 08/08/2024, so the resident could receive their eye vitamins that were supplied.

<Resident 20>

Review of an NSA for Resident 20, dated 08/08/2024, showed the resident had diagnoses of [redacted] and required medication administration assistance from the facility.

Review of Resident 20's August 2024 MAR showed an order for quetiapine (an antipsychotic medication used to treat major depressive disorder and other mental illnesses) to be given daily. Further review showed it was not given on 08/23/2024.

In an interview on 09/18/2024 at 1:30 PM, Staff B, stated Resident 20 had not received quetiapine as ordered on 08/23/2024 because it had not been ordered in time from the pharmacy.

This is an uncorrected deficiency previously cited on 07/03/2024 and a recurring deficiency previously cited 12/29/2022.

Plan/Attestation Statement

08/16/2024 through the morning dose on 09/06/2024 AM, the resident's eye vitamins were not administered.

In an interview on 08/28/2024 at 2:45 PM, Staff V, Care Partner, stated when Resident 1 was admitted to the facility, they had a order for the eye vitamin. Staff V stated the eye vitamin was not available in the facility, so the Resident's family brought in medication, but it did not match the doctor's prescription. Staff V further stated that there were still no eye vitamins on hand that could be given as ordered.

In an interview 09/18/2024, Staff B, Health and Wellness Specialist, stated they obtained an order on [redacted]/2024 (36 days after the resident admitted) to give the eye medication that the family had brought in on 08/03/2024, so the resident could receive their eye vitamins that were supplied.

<Resident 20>

Review of an NSA for Resident 20, dated 06/08/2024, showed the resident had diagnoses of [redacted] and required medication administration assistance from the facility.

Review of Resident 20's August 2024 MAR showed an order for quetiapine (an antipsychotic medication used to treat major depressive disorder and other mental illnesses) to be given daily. Further review showed it was not given on 08/23/2024.

In an interview on 09/18/2024 at 1:30 PM, Staff B, stated Resident 20 had not received quetiapine as ordered on 08/23/2024 because it had not been ordered in time from the pharmacy.

This is an uncorrected deficiency previously cited on 07/03/2024 and a recurring deficiency previously cited 12/28/2022.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2479	Compliance Determination # 46420
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 5 of 8	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

WAC 388-78A-3140 Responsibilities during inspections. The assisted living facility must:

(2) Provide requested records to the representatives of the department; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide grievance forms requested by the department from 1 of 1 administrator (Staff A). This failure delayed and impeded the department's ability to investigate concerns related to abuse and neglect in the facility.

Findings included...

Review of the facility's grievance book showed a grievance log for the year 2024 and contained forms labeled "Resident or Family Grievance/Complaint/Concerns." All of the completed grievances reviewed appeared to be submitted by residents or family members of residents.

In an interview on 08/27/2024 at 1:10 PM with Staff A, Executive Director, the department requested access to the binder containing grievances from staff related to resident care. Staff A stated that all grievances were kept in the binder that was previously provided to the department for review. Staff A stated that all other grievances not in the binder provided, were related to personnel issues, and were kept in employee files. When asked about staff grievances turned in regarding the care or treatment of a resident by another staff member, Staff A stated that all grievances related to care or treatment of a resident were located in the binder previously provided. When the investigator shared that the grievance forms in the binder differed from the forms that employees stated they had filled out, Staff A stated that if staff turned in an Employee Statement/Concern form, they would have been asked to complete one of the Resident or Family Grievance/Complaint/Concerns forms in the binder. When the investigator shared that none of the forms in the binder appeared to be completed or submitted by staff members, Staff A stated they would go through the staff files to check for staff grievances again.

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-3140 Responsibilities during inspections. The assisted living facility must:

(2) Provide requested records to the representatives of the department; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide grievance forms requested by the department from 1 of 1 administrator (Staff A). This failure delayed and impeded the department's ability to investigate concerns related to abuse and neglect in the facility.

Findings included…

Review of the facility's grievance book showed a grievance log for the year 2024 and contained forms labeled "Resident or Family Grievance/Complaint/Concerns." All of the completed grievances reviewed appeared to be submitted by residents or family members of residents.

In an interview on 08/27/2024 at 1:10 PM with Staff A, Executive Director, the department requested access to the binder containing grievances from staff related to resident care. Staff A stated that all grievances were kept in the binder that was previously provided to the department for review. Staff A stated that all other grievances not in the binder provided, were related to personnel issues, and were kept in employee files. When asked about staff grievances turned in regarding the care or treatment of a resident by another staff member, Staff A stated that all grievances related to care or treatment of a resident were located in the binder previously provided. When the investigator shared that the grievance forms in the binder differed from the forms that employees stated they had filled out, Staff A stated that if staff turned in an Employee Statement/Concern form, they would have been asked to complete one of the Resident or Family Grievance/Complaint/Concerns forms in the binder. When the investigator shared that none of the forms in the binder appeared to be completed or submitted by staff members, Staff A stated they would go through the staff files to check for staff grievances again.

Statement of Deficiencies	License #: 2479	Compliance Determination # 46420
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
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In an interview on 08/27/2024 at 2:01 PM with Staff A and Staff B, Health and Wellness Specialist, Staff A stated grievances written by a staff member about another staff member were internal documents and that they were not required to provide those to the department. A second request was made by the department for grievances written by staff members about concerns related to a resident or resident care. Staff A stated those types of grievances would be in the binder previously provided. When the investigator shared that staff had indicated that they had submitted Employee Statement/Concern Forms about the care of residents and they were not present in the binder provided, Staff A stated they would look again.

In an interview on 08/27/2024 at 2:37 PM with Staff A and Staff B, Staff A stated that they had located two grievances related to residents. When asked if there were any grievances received that named Staff O, Care Partner, Staff A stated they did not have any grievances related to Staff O. Staff
A further stated that an incident had occurred on 08/10/2024, involving Staff O and Resident 3, and had been communicated to them verbally. Staff A stated no other grievances had been turned in.

Review of the grievances provided on 08/27/2024 by Staff A showed two documents:

-Employee Statement/Concern Form, dated 07/07/2024, submitted by Staff U, Care Partner, about Staff P, Care Partner.
-Employee Statement/Concern Form, dated 07/11/2024, submitted by Staff E, Med Aide, about Staff N, Care Partner.

In an interview on 08/29/2024 at 1:45 PM, Staff A provided copies of investigations, including copies of three handwritten statements, that Staff A identified as part of their investigation into the 08/10/2024 incident involving Staff O.

Review of the statements provided on 08/29/2024 showed three documents:

-A handwritten narrative covering two pages with Staff K's, Care Partner, name on the bottom of both pages and dates of 07/24/2024 and 07/25/2024 on the top line of the documents.
-A handwritten narrative covering two pages with Staff L's, Care Partner, name on the bottom of both pages. The narrative included references to 07/24/2024 and 07/25/2024 on the first page, and 07/25/2024 on the second page.
- An undated, unsigned handwritten narrative covering half the page, regarding an interaction between Staff O and Resident 3.

In an interview on 09/06/2024 at 3:28 PM Staff K, was shown the handwritten statements provided to the department by Staff A. After reviewing the document, Staff K stated that they wrote the handwritten statement dated 07/25/2024 but that the documentation was incomplete. Staff K further stated that they and Staff L each wrote out a statement along with grievance forms related to concerns that arose on

In an interview on 08/27/2024 at 2:01 PM with Staff A and Staff B, Health and Wellness Specialist, Staff A stated grievances written by a staff member about another staff member were internal documents and that they were not required to provide those to the department. A second request was made by the department for grievances written by staff members about concerns related to a resident or resident care. Staff A stated those types of grievances would be in the binder previously provided. When the investigator shared that staff had indicated that they had submitted Employee Statement/Concern Forms about the care of residents and they were not present in the binder provided, Staff A stated they would look again.

In an interview on 08/27/2024 at 2:37 PM with Staff A and Staff B, Staff A stated that they had located two grievances related to residents. When asked if there were any grievances received that named Staff O, Care Partner, Staff A stated they did not have any grievances related to Staff O. Staff
A further stated that an incident had occurred on 08/10/2024, involving Staff O and Resident 3, and had been communicated to them verbally. Staff A stated no other grievances had been turned in.

Review of the grievances provided on 08/27/2024 by Staff A showed two documents:

-Employee Statement/Concern Form, dated 07/07/2024, submitted by Staff U, Care Partner, about Staff P, Care Partner.
-Employee Statement/Concern Form, dated 07/11/2024, submitted by Staff E, Med Aide, about Staff N, Care Partner.

In an interview on 08/29/2024 at 1:45 PM, Staff A provided copies of investigations, including copies of three handwritten statements, that Staff A identified as part of their investigation into the 08/10/2024 incident involving Staff O.

Review of the statements provided on 08/29/2024 showed three documents:

-A handwritten narrative covering two pages with Staff K's, Care Partner, name on the bottom of both pages and dates of 07/24/2024 and 07/25/2024 on the top line of the documents.
-A handwritten narrative covering two pages with Staff L's, Care Partner, name on the bottom of both pages. The narrative included references to 07/24/2024 and 07/25/2024 on the first page, and 07/25/2024 on the second page.
- An undated, unsigned handwritten narrative covering half the page, regarding an interaction between Staff O and Resident 3.

In an interview on 09/06/2024 at 3:26 PM Staff K, was shown the handwritten statements provided to the department by Staff A. After reviewing the document, Staff K stated that they wrote the handwritten statement dated 07/25/2024 but that the documentation was incomplete. Staff K further stated that they and Staff L each wrote out a statement along with grievance forms related to concerns that arose on

07/24/2024 and 07/25/2024 while training Staff O. Staff K stated that they also sent a text with photos of all the pages included and left the original documents (hard copies) under Staff A's door. Staff K confirmed that the grievance forms they and Staff L filled out were Employee Statement/Concern Forms

Review of a text sent to a group chat that consisted of Staff A, Staff B, Staff C, Resident Care Coordinator, and Staff D, Resident Care Coordinator, on July 27, 2024 at 12:02 PM by Staff K, showed documentation that read "We (Staff K and Staff L) filled out two grievance forms. We slipped them under [Staff A]'s door but we wanted to send you all copies." Further review showed photos of the grievance forms, and the handwritten statements mentioned above, attached to the text.

In an interview on 09/06/2024 at 12:25 PM, Staff M, Care Partner, stated they filled out a grievance form and wrote a statement on the back side of the form on 08/10/2024. When presented with the copy of the unsigned, undated handwritten statement provided to the department about Staff O, Staff M confirmed that it was the statement they wrote on the back of the grievance form they submitted.

In an interview on 09/06/2024 at 1:42 PM, Staff G, Business Office Director, stated that they had received grievances from staff. Staff G confirmed that the grievance forms that they were referring to were the Employee Statement/Concern Forms. Staff G stated that they received three grievances regarding Staff P, Care Partner, and one grievance regarding Staff O. Staff G pulled out a binder and flipped through multiple grievance forms. Staff G confirmed all of the grievance forms they were in possession of were kept in the binder

Review of the grievances provided in response to the department's request showed three Employee Statement/Concern Forms:

- An Employee Statement/Concern Form dated 08/10/2024 and filled out by Staff M regarding Staff O (department previously provided with only the backside of the form containing a written statement).
- An Employee Statement/Concern Form dated 08/06/2024 and filled out by Staff U, Care Partner, regarding Staff P (no portion of which had been provided previously).
- An Employee Statement/Concern Form dated 08/11/2024 and filled out by Staff J, Care Partner, regarding Staff O (no portion of which had been provided previously).

Review of the documents did not show the grievance forms submitted by Staff K and L.

This is an uncorrected deficiency previously cited on 07/03/2024.

07/24/2024 and 07/25/2024 while training Staff O. Staff K stated that they also sent a text with photos of all the pages included and left the original documents (hard copies) under Staff A's door. Staff K confirmed that the grievance forms they and Staff L filled out were Employee Statement/Concern Forms.

Review of a text sent to a group chat that consisted of Staff A, Staff B, Staff C, Resident Care Coordinator, and Staff D, Resident Care Coordinator, on July 27, 2024 at 12:02 PM by Staff K, showed documentation that read "We (Staff K and Staff L) filled out two grievance forms. We slipped them under [Staff A]'s door but we wanted to send you all copies." Further review showed photos of the grievance forms, and the handwritten statements mentioned above, attached to the text.

In an interview on 09/06/2024 at 12:25 PM, Staff M, Care Partner, stated they filled out a grievance form and wrote a statement on the back side of the form on 08/10/2024. When presented with the copy of the unsigned, undated handwritten statement provided to the department about Staff O, Staff M confirmed that it was the statement they wrote on the back of the grievance form they submitted.

In an interview on 09/06/2024 at 1:42 PM, Staff G, Business Office Director, stated that they had received grievances from staff. Staff G confirmed that the grievance forms that they were referring to were the Employee Statement/Concern Forms. Staff G stated that they received three grievances regarding Staff P, Care Partner, and one grievance regarding Staff O. Staff G pulled out a binder and flipped through multiple grievance forms. Staff G confirmed all of the grievance forms they were in possession of were kept in the binder.

Review of the grievances provided in response to the department's request showed three Employee Statement/Concern Forms:

- An Employee Statement/Concern Form dated 08/10/2024 and filled out by Staff M regarding Staff O (department previously provided with only the backside of the form containing a written statement).
- An Employee Statement/Concern Form dated 08/06/2024 and filled out by Staff U, Care Partner, regarding Staff P (no portion of which had been provided previously).
- An Employee Statement/Concern Form dated 08/11/2024 and filled out by Staff J, Care Partner, regarding Staff O (no portion of which had been provided previously).

Review of the documents did not show the grievance forms submitted by Staff K and L.

This is an uncorrected deficiency previously cited on 07/03/2024.

Statement of Deficiencies	License # 2479	Compliance Determination # 45420
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 8 of 8	Licensee: PSL Associates, LLC	10/04/2024

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: 10/17/24

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: 127477
Compliance Determination #: 40847
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 05/06/2024 through 07/03/2024
Complainant Contact Date(s):

Allegation(s):
Resident to resident altercation.

Investigation Methods:

Sample:	Total residents: 105 Resident sample size: 3 Closed records sample size: 0
Observations:	Alleged Victim Alleged Perpetrator Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Alleged Perpetrator Executive Director Health and Wellness Specialist Resident Hospice Nurse
Record Reviews:	-Disclosure of Services -Characteristic roster -Staff roster -Resident face sheet -Resident care plans -Progress notes -Incident reports -Medication Services Policy -Temporary service plans -Medication administration records -Provider orders -Hospice plan of care

Investigation Summary:

Facility management was interviewed, and they reported that no investigation was done following the resident-to-resident altercation. Review of the Alleged Victim's care plan, showed that it failed to reflect their history of known behaviors that triggered aggression from other residents. Failed facility practice identified under WAC 388-78A-2371 Investigations (1)(2)(3)(4). Facility already out of compliance as of 06/11/2024. Failed facility practice identified under WAC 388-78A-2120 Monitoring residents' well-being (3)(b)(4). Facility already out of compliance as of 06/11/2024. Failed facility practice identified and cited under WAC 388-78A-2140 Negotiated service agreement contents (5).

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: 126436
Compliance Determination #: 40847
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 05/06/2024 through 07/03/2024
Complainant Contact Date(s): 05/10/2024, 06/28/2024

Allegation(s):
New medication orders not processed timely.

Investigation Methods:

Sample:	Total residents: 105 Resident sample size: 3 Closed records sample size: 0
Observations:	Alleged Victim Residents Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Alleged Victim Executive Director Health and Wellness Specialist Hospice Nurse Reporter
Record Reviews:	-Disclosure of Services -Characteristic roster -Staff roster -Resident face sheet -Resident care plans -Progress notes -Incident reports -Medication Services Policy -Temporary service plans -Medication administration records -Provider orders -Hospice plan of care

Investigation Summary:

Record review showed that medication orders written for the Alleged Victim were not added to the resident's medication administration record in a timely manner, resulting in a delay in medication availability for the resident. Documents requested as part of the complaint investigation were not provided by the facility after multiple requests. Failed facility practice identified and cited under WAC 388-78A-2240 Nonavailability of medications. This is a recurring deficiency previously cited on 12/28/2022. Failed facility practice identified and cited under WAC 388-78A-3140 Responsibility during inspections (2).

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 # 40847
Plan of Correction | North Point Village, Assisted Living & Memory Care | Completion Date
Page 1 of 9 | Licensee: PSL Associates, LLC | 07/03/202

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 05/06/2024, 05/06/2024 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): 127477, 126436

The following sample was selected for review during the unannounced on-site visit: 3 of 105 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: 07/16/2024

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.

Administrator (or Representative) 7/24/24 Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that behavioral interventions used to decrease or prevent physical altercations between residents were included in the negotiated service agreement of 1 of 2 residents (Resident 1). This failure placed Residents 1 at increased risk for ongoing physical altercations with other residents, and placed facility residents at increased risk for injury, psychosocial harm, and decreased quality of life.

Findings included...

Review of a face sheet for Resident 1, dated 11/22/2023, showed that the resident had diagnoses including [redacted] and [redacted].

Review of an incident report for Resident 1, dated 03/09/2024 at 6:51 PM, showed that Resident 1 went to grab a piece of food off Resident 2's plate, Resident 2 waved their hand at Resident 1, then Resident 2 pulled their arm back with a closed fist but did not swing it toward Resident 1. The incident report showed that Resident 1, with both hands open, went toward Resident 2's neck, but did not make contact because Resident 1 lost their balance.

Review of a progress note for Resident 1, with an effective date of 03/09/2024 at 7:33 PM, showed that Resident 1 was observed making a closed fist and "pushing [their] arm out" toward Resident 2, making contact with Resident 2's right arm.

Review of a progress note for Resident 1, with an effective date of 03/24/2024 at 9:54 PM, showed that Resident 1 attempted to grab Resident 2's napkin repeatedly, Resident 2 appeared very annoyed, and staff attempted to redirect Resident 1 multiple times, unsuccessfully. The note showed that Resident 2 "retaliated" by smacking Resident 1's hand away and Resident 1 responded by attempting to get "aggressive."

Statement of Deficiencies	License #: 2479	Compliance Determination # 40647
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 3 of 9	Licensee: PSL Associates, LLC	07/03/202

Review of a negotiated service agreement (NSA) for Resident 1, dated 05/08/2024, showed that it failed to indicate Resident 1 had a history of physical aggression toward other residents. Further review of the NSA showed that it failed to identify interventions to be used by staff to decrease or prevent physical altercations between Resident 1 and other residents.

In an interview on 05/06/2024 at 11:13 AM, Staff B, Health and Wellness Specialist, stated that Resident 1 and Resident 2 had an altercation during mealtime recently, that Resident 1 took something from Resident 2, and that Resident 2 swatted Resident 1 away. Staff B stated that staff witnessed the incident but had not thought much of it because Resident 2 made no contact with Resident 1. Staff B stated no care plan changes were made.

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) 8/16/24.

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

Administrator (or Representative) 7/23/24 Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure prescribed medications were obtained from a resident's comfort kit in a timely manner for 1 of 1 resident (Resident 1). This failure resulted in Resident 1 not receiving their end of life medications as prescribed, which contributed to unmanaged nausea, pain, and signs and symptoms of anxiety and agitation, and placed Resident 1 at increased risk for health complications related to an untreated infection.

Findings included...

In an interview on 05/10/2024 at 10:23 AM, Collateral Contact 2 (CC2), Hospice Medical

Social Worker, stated they requested Resident 1's Medication Administration Record (MAR) from the facility so they could reconcile it with the resident's hospice orders, and had found they did not match. CC2 stated that Resident 1's medication orders were faxed to the facility, but they were not entered onto the resident's MAR in a timely manner. CC2 stated that a hospice medical assistant hand delivered Resident 1's medication orders to the facility on 04/03/2024. CC2 stated the medical assistant handed the orders directly to Staff E, Concierge. CC2 stated that Staff E told the medical assistant they had not received Resident 1's orders because the facility was having a hard time with their fax machine. CC2 stated that when the medical assistant handed Staff E Resident 1's orders, they showed Staff E the fax confirmations showing the facility's fax machine had received the orders sent on prior attempts.

<Psychoactive Medication>

Review of a skilled nursing visit note written by Collateral Contact 3 (CC3), Hospice Registered Nurse, dated 02/16/2024 at 8:16 PM, showed that Resident 1 was scheduled for a skilled nursing visit on 02/17/2024 so the nurse could assess the effectiveness of Resident 1's prescribed quetiapine (a medication used to balance levels of hormones in the brain that help regulate mood, behaviors, and thoughts). The note showed that Resident 1 was to take the quetiapine daily at bedtime.

Review of a skilled nursing visit note, dated 02/17/2024 at 2:49 PM and written by Collateral Contact 4 (CC4), Hospice Registered Nurse, showed that Staff C, Medication Technician, told them Resident 1 did not receive their quetiapine the night prior because the facility never received the order for it. The visit note showed that CC4 was having the order refaxed.

Review of a progress note for Resident 1, dated 03/09/2024 at 7:33 PM and written by Staff C, showed that Resident 1 was involved in a physical altercation with Resident 2 that day. The progress note showed that Resident 1's hospice provider was notified, and the hospice provider was faxing over an order for "as needed" quetiapine (in addition to the scheduled dose at night).

Review of a skilled nursing visit note for Resident 1, dated 03/28/2024 at 2:20 PM and written by Collateral Contact 5 (CC5), Hospice Registered Nurse, showed that facility care staff requested a medication order to manage Resident 1's agitation and anxiety. Review of the visit note showed that Resident 1 was "constantly pacing and unable to sit." CC5 documented that Resident 1 already had an order for scheduled and "as needed" quetiapine for anxiety and agitation.

Review of a skilled nursing visit note for Resident 1, dated 04/03/2024 at 11:03 AM and written by CC1, Hospice Registered Nurse, showed that CC1 identified a medication discrepancy during their nursing visit with Resident 1 that day. The visit note showed that the orders for Resident 1's quetiapine were not on their medication administration record (MAR), so all their medication orders were being refaxed to the facility again. The visit note showed that CC1 spoke with Staff B, Health and Wellness Specialist, that day.

The visit note showed that Staff B stated the facility had not received the orders for Resident 1's "as needed" or scheduled quetiapine twice weekly before showers, which was ordered the day prior so the hospice aids could assist Resident 1 with showering. Review of the visit note showed that Staff B gave CC1 a direct fax number so Resident 1's orders could be sent directly to Staff B by the hospice intake worker. The visit note showed that all Resident 1's orders were refaxed that day and that CC1 asked Staff B to notify them if the orders were not received.

Review of a skilled nursing visit note for Resident 1, dated 04/07/2024 at 10:20 PM and written by CC1, showed that CC1 identified a medication discrepancy that day. The visit note showed that Resident 1's orders for "as needed" quetiapine and scheduled quetiapine twice weekly with showers were still not on Resident 1's MAR, even though the orders were physically brought to the facility the week prior.

Review of a MAR for Resident 1, dated May of 2024, showed that the resident's order for scheduled quetiapine two times weekly prior to showers for agitation was not added to their MAR until 04/12/2024. Further review of the MAR showed that the resident's order for quetiapine every four hours "as needed" for agitation was not added to their MAR until 05/06/2024.

In an interview on 05/06/2024 at 12:21 PM, CC1stated that it took weeks for the facility to get Resident 1's medication orders entered into their MAR, so the resident's medications were not available right away. CC1 stated that the facility did not like to give Resident 1's quetiapine "as needed" before showers as ordered, so the hospice provider added the scheduled dose of quetiapine. CC1 stated that the quetiapine was helpful for showering Resident 1 (who became agitated and combative during showers).

In an interview on 05/10/2024 at 10:23 AM, CC2 stated that Resident 1's quetiapine orders still had not been entered onto the resident's MAR by 04/10/2024 CC2 stated they thought the quetiapine would have been beneficial for Resident 1's cares because Resident 1 had "stranger danger" and that the hospice aids, who Resident 1 was not familiar with, were the ones who were to shower Resident 1.

Review of Resident 1's hospice plan of care, for certification period 05/16/2024 through 08/13/2024, showed that Resident 1's scheduled, nightly quetiapine was initially ordered on 02/16/2024. The plan of care showed that Resident 1 was ordered quetiapine "as needed" every 4 hours for agitation on 02/16/2024.

On 06/21/2024 at 4:49 PM, an email was sent, by the department, to Staff A and Staff B requesting Resident 1's MARs for February of 2024 through April of 2024. There was no response to the email and no MARs were received. The facility failed to provide documentation to show that Resident 1 received their prescribed quetiapine in a timely manner.

<Antibiotic Medication>

Review of a skilled nursing visit note, dated 03/04/2024 at 10:54 AM and written by CC1, showed that Resident 1 began showing symptoms of a urinary tract infection on 03/02/2024, including urinary frequency, dark, cloudy urine, and visual hallucinations. The visit note showed that antibiotics were prescribed on 03/03/2024, they arrived at the facility on [redacted]/2024, though they were not administered because the order had not been entered into Resident 1's MAR yet. The visit note showed that Staff D, Medication Technician, asked Staff B to put the antibiotic order on Resident 1's MAR that day so they could be started "ASAP."

Review of a skilled nursing visit note for Resident 1, dated 03/06/2024 at 10:05 AM and written by CC1, showed that Resident 1 still had not received the antibiotic prescribed for their urinary tract infection. The visit note showed that CC1 spoke with Staff B that day, CC1 asked Staff B to enter Resident 1's antibiotic order, and Staff B told CC1 that they needed the antibiotic order faxed again. The visit note showed that the antibiotic order was refaxed to the facility again that day.

On 06/21/2024 at 4:49 PM, an email was sent, by the department, to Staff A and Staff B requesting Resident 1's MARs for February of 2024 through April of 2024. There was no response to the email and no MARs were received. The facility failed to provide documentation to show that Resident 1 received their prescribed antibiotic in a timely manner.

<Nausea Medication>

Review of a hospice plan of care for Resident 1, dated 02/16/2024, showed that on that day, Resident 1 was prescribed prochlorperazine (a medication used to treat nausea), every six hours "as needed" for nausea and vomiting

In an interview on 05/06/2024 at 12:21 PM, CC1 stated that on 05/05/2024, they asked a medication technician to give Resident 1 some prochlorperazine because the resident was nauseous. CC1 stated they were told the medication was not available.

Review of a progress note for Resident 1, with an effective date of 05/06/2024 at 1:17 PM and written by Staff F, Medication Technician, showed that Staff F called Resident 1's hospice nurse because the resident was coughing and "spitting up," but the resident did not have any "as needed" medications for nausea on their MAR. The note showed that the hospice nurse came out and administered Resident 1 prochlorperazine for nausea themselves.

Review of Resident 1's MAR, dated May of 2024, showed there was no order for prochlorperazine on Resident 1's MAR.

On 06/21/2024 at 4:49 PM, an email was sent, by the department, to Staff A and Staff B requesting Resident 1's MARs for February of 2024 through April of 2024. There was no response to the email and no MARs were received. The facility provided documentation to show that Resident 1 received their prochlorperazine as ordered.

<Pain Medication>

Review of a skilled nursing visit note for Resident 1, dated 04/03/2024 at 11:03 PM and written by CC1, showed that Resident 1 was assessed to be in pain as evidenced by frowning, fidgeting, and distressed pacing. The note showed that CC1 spoke with Staff B that day, that Staff B stated the facility had not received orders for Resident 1's comfort medications, and that Staff B provided CC1 with a fax number that went directly to Staff B. The note showed that a hospice intake worker refaxed all of Resident 1's orders to the fax number provided.

Review of a skilled nursing visit note for Resident 1, dated 04/23/2024 at 11:26 PM and written by CC1, showed that Resident 1 was assessed to be in pain as evidenced by grimacing and withdrawal.

Review of a progress note for Resident 1, with an effective date of 05/06/2024 at 8:28 PM and written by Staff D, showed that Resident 1 was "very uncomfortable." The note showed that Resident 1 appeared to be in pain as evidenced by facial grimacing, constant body movements, moving their arms up and down, and moving their legs back and forth. The note showed that Resident 1's daughter asked Staff D to give the resident more morphine (a medication used to treat pain) because it had been effective when given by the hospice nurse earlier that day. The note showed that Staff D told Resident 1's daughter they would have to talk to Staff B about it. The note showed that Staff B finally entered the morphine order onto Resident 1's MAR and gave Staff D "permission" to give it that day.

Review of a progress note for Resident 1, with an effective date of 05/07/2024 at 6:33 AM and written by Staff G, Medication Technician, showed that Resident 1 took their first two doses of morphine that shift with no problems and slept through the night.

Review of a resident monthly assignment report for Resident 1, dated May of 2024, showed that the resident's order for scheduled and "as needed" morphine for severe pain were received on 05/07/22024.

Review of a hospice plan of care for Resident 1, for certification period 05/16/2024 through 08/13/2024, showed that Resident 1's order for morphine every two hours as needed for severe pain was initially ordered on 04/29/2024.

In an interview on 07/03/2024 at 12:00 PM, CC1 stated that hospice provided the facility with comfort (end of life) medications in a "comfort kit" for Resident 1. CC1 stated that

the facility did not utilize (obtain from the comfort kit) the medications provided.

This is a recurring deficiency previously cited on 12/28/2022.

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) 8/16/24.

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

Administrator (or Representative) 7/23/24 Date

WAC 388-78A-3140 Responsibilities during inspections. The assisted living facility must:

(2) Provide requested records to the representatives of the department; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide records requested by the department during a complaint investigation for 1 of 1 resident (Resident 1). This failure delayed the investigation process and limited the department's ability to investigate concerns related to the availability of prescribed medications for Resident 1, and placed facility residents who required assistance with medications at increased risk for delayed medication order processing and administration.

Findings included..

In an interview on 05/06/2024 at 12:21 PM, Collateral Contact 1 (CC1), Hospice Nurse Case Manager, stated that it took weeks for the facility to get Resident 1's medication orders entered into their medication administration record (MAR), so the resident's medications were not available right away.

In an interview on 05/10/2024 at 10:23 AM, Collateral Contact 2 (CC2), Hospice Medical Social Worker, stated they requested Resident 1's MAR from the facility so they could reconcile it with the resident's hospice orders, but they did not match. CC2 stated that Resident 1's medication orders were faxed to the facility but they were not entered onto the resident's MAR in a timely manner.

On 05/06/2024, an email was sent to Staff A, Executive Director, and Staff B, Health and Wellness Specialist, requesting Resident 1's MARs for February 2024 through May of 2024. Only the MARs for May of 2024 were received.

On 06/21/2024 at 4:49 PM, an email was sent to Staff A and Staff B requesting Resident 1's MARs for February of 2024 through April of 2024. There was no response to the email and no MARs were received.

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) 8/16/24 .

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

Administrator (or Representative) 7/23/24 Date