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

11/04/2024

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) 49784 (Completion Date 11/04/2024) and 44863 (Completion Date 08/27/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/04/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

The Department staff who did the On Site verification:
Brian Zbylski, ALF Licensor
Veronica Jackson, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager

Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: North Point Village, Assisted Living & Memory Care **Provider Type:** Assisted Living Facility
License/Cert.#: 2479
Intake ID: 143047
Compliance Determination #: 44863
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sylvia Shauvin
Investigation Date(s): 07/05/2024 through 08/27/2024
Complainant Contact Date(s): 08/23/2024

Allegation(s):

1 - Facility doesn't resolve issues related to residents' access to working phones
2 - Facility increases the rent every few months
3 - Trip/fall hazards e.g. slippery floors
4 - Medications aren't provided
5 - Staff doesn't provide wraps to a resident's legs, as ordered
6 - Food is burnt

Investigation Methods:

Sample:	Total residents: 101 Resident sample size: 8 Closed records sample size: 4
Observations:	Residents' safety and well-being Any injuries to residents Any unmet residents' needs Medication passes Meals Staff's response to residents' needs/concerns
Interviews:	Ten residents, including alleged victim (AV) Eight resident representatives Hospice Social Worker Case Manager Two facility caregivers Four medication aides/caregivers Two Resident Care Coordinators (RCCs) Facility licensed nurse/Health and Wellness Director Business Office Manager Administrator
Record Reviews:	Sampled residents' Face Sheets, assessments, care plans, Progress Notes, and medication administration records (MARS) Staffing schedules Facility incident/injury investigation documents Admission Agreement

Disclosure of Services
Grievance document
Eight sampled staff's credentials and training

Investigation Summary:

1 - Resident and staff interviews showed that various options were available for them to voice grievances with the facility including face-to-face contact, monthly resident council and town hall meetings, grievance forms, and an ombudsman. During a prior investigation, failed facility practice was found and documented in a 06/14/2024 Statement of Deficiencies (SOD) under Washington Administrative Code (WAC) 388-78a-2930(1)(c)(2)(a-b) Communication system. This was related to facility's failure to provide residents with access to functioning phone(s). Investigation and determination of facility's compliance with assisted-living requirements related to communication is pending due to an ongoing follow up inspection of failed facility practices related to policy and procedure.

2 - Interview with the BOM and facility nurse showed the facility used a system for determining costs for residents' room and board, and care utilizing a point system that was based on the nursing assessment of residents' needs. They stated the facility notified residents and if applicable, residents' representatives, in writing of the charges. The facility notified them of any changes in the charges by providing 30 day written notice of those changes via postal or electronic mail. Investigation findings did not support failed facility practice/warrant citation related to alleged issue.

3 - Department investigator had no observations of environment and equipment hazards. Use of various interventions, such as motion alarms and traction strips on floors, were observed. Staff was observed providing mobility assistance. However, investigation and determination of facility's compliance with assisted-living requirements related to residents' safety is pending due to an ongoing follow up inspection of failed facility practices related to care and services..

4 - Medication aides were observed utilizing a system to check medications against prescribers' orders before delivering medications. Interviews with residents and staff; and reviews of sampled residents' MARS showed the facility omitted a sampled resident's medication. Deficient facility practice was found and documented in a 08/27/2024 SOD under WAC 388-78-2210(1)(b) Medication services.

5 - Alleged victim (AV) was observed with wraps to legs. In an interview with the AV, they stated the staff provided the wraps. In interviews with staff, they stated the AV sometimes refused or removed the wraps after staff applied them. Residents' need for, and behaviors related to the wraps were addressed in their care plan. During a prior investigation, deficient facility practice was found related to the facility's failure to provide wraps to a resident's legs, as ordered. The deficiency was documented in the 06/14/2024 SOD under WAC 388-78a-2160 Implementation of Negotiated Service Agreement. Investigation and determination of facility's compliance with assisted-living requirements related to providing residents with needed care is pending due to an ongoing follow up inspection of failed facility practices related to care and services.

6 - Department investigator had no observations of burned food and residents interviewed had no concerns about it. Facility had several avenues for residents to provide dietary staff with feedback about the food, such as monthly meetings with dietary staff. Investigation and determination of facility's compliance with assisted-living requirements related to food and nutrition is pending due to on ongoing investigation with deficient practice identified related to food services.

Conclusion / Action:

☐ 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: 137166
Compliance Determination #: 44863
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sylvia Shauvin
Investigation Date(s): 07/05/2024 through 08/27/2024
Complainant Contact Date(s): 07/09/2024, 08/27/2024

Allegation(s):
Facility didn't give a resident their medication

Investigation Methods:

Sample:	Total residents: 101 Resident sample size: 8 Closed records sample size: 4
Observations:	Residents' safety and well-being Any residents' injuries Any unmet residents' needs Medication passes Staff's response to residents' needs/concerns
Interviews:	Ten residents, including alleged victim (AV) Eight resident representatives Hospice Social Worker Case Manager Two facility caregivers Four medication aides/caregivers Two Resident Care Coordinators (RCCs) Facility licensed nurse/Health and Wellness Director Business Office Manager Administrator
Record Reviews:	Sampled residents' Face Sheets, assessments, care plans, Progress Notes, and medication administration records (MARS) Staffing schedules Facility incident/injury investigation documents Admission Agreement Disclosure of Services Hospital records pertaining to AV Eight sampled staff's credentials and training

Investigation Summary:

1 - The AV was observed with a head wound that they stated they sustained from a fall during a period of time when facility didn't provide their medication. The AV stated the medication omission and possible effects from it frightened them. Resident, representative, and staff interviews showed the facility did not provide the AV medication, as ordered. Failed facility practice was found and documented in a 08/27/2024 Statement of Deficiencies under Washington Administrative Code 388-78a-2210(1)(b) Medication services.

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 # 44863
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 1 of 5	Licensee: PSL Associates, LLC	08/27/2024

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 07/05/2024, 07/05/2024 and 08/27/2024 of:

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

This document references the following complaint number(s): 138533, 139056, 138916, 138973, 142562, 143047, 143546, 137166, 141285

The following sample was selected for review during the unannounced on-site visit: 8 of 101 current residents and 4 former residents.

The department staff that investigated the Assisted Living Facility:

Sylvia Shauvin, Complaint 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 — 09/11/2024 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.

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Residential Care Services

Date

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

Administrator (or Representative)

9/12/24
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement a safe system for medication refills and resident representative contact to ensure residents received their medication as ordered for 1 of 4 sampled residents that were discharged (Resident 2). This failure resulted in the abrupt discontinuation of Resident 2's sedative medication, contributed to medication withdrawal symptoms that required a hospital evaluation, feelings of fear, and placed the resident at risk for serious harm.

Findings included...

Review of the facility's medication policy titled, "HS 065," dated January 2020, showed that if the facility was not able to obtain medications in a timely manner, the facility should notify the residents' representatives as well as the pharmacy and/or the prescriber to obtain the medication.

Review of the Negotiated Service Plan (NSP) for Resident 2, dated 05/22/2024, showed the resident was diagnosed with [redacted], and [redacted]. The NSP further showed Resident 2 required staff's assistance to take medications and the licensed nurse or medication aide was responsible for re-ordering medications seven days to one week prior to the last dose of medication.

Review of the June 2024 medication administration record (MAR) for Resident 2, showed a prescriber's order, dated 2/4/2023 for clonazepam (medication used to treat seizures and anxiety, which if abruptly stopped can cause irritability, anxiety, difficulty with concentration, shaking, seizures, psychotic reactions, delirium, hallucinations, and death) to be taken every night. The June 2024 MAR also showed staff did not provide the clonazepam from 06/17/2024 to 06/27/2024.

Review of Resident 2's Progress Notes showed the following:

Administrator (or Representative) Date

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Review of Resident 2's Progress Notes showed the following:

-On 06/20/2024 at 4:35 PM the resident stated people were in Resident 2's room.
-On 06/24/2024 at 12:33 AM the resident had increased fidgeting and shakiness.
-On 06/25/2024 at 12:37 AM the resident was "very unsteady," "very confused," and "shakey."
-On 06/25/2024 at 5:53 AM the resident exhibited increased confusion and restlessness, and was trying to dismantle a lamp.
-On 06/26/2024 at 5:32 AM the resident had sleeplessness and fidgeting.
-On 06/27/2024 at 3:33 AM, the resident had been seen in the emergency room the day before because they were "unresponsive."

Review of Resident 2's hospital records, dated 06/24/2024, showed the resident was seen for evaluation related to an unwitnessed fall and making "off the wall" statements, that had recently worsened. The 06/24/2024 hospital record also showed Resident 2 had an abrasion on the head.

Review of Resident 2's hospital records, dated 06/26/2024, showed the resident was seen for evaluation because they presented with complaints of headache, feeling increasingly "globally weak", and "not feeling well."

In an interview on 07/03/2024 at 2:45 PM, Collateral Contact 1 (CC1), representative for Resident 2, stated that Resident 2 had been taking clonazepam at bedtime to help with sleep since 1989. CC1 stated that on 07/02/2024, they reviewed the June 2024 MAR for Resident 2 and discovered the facility did not provide the clonazepam from 06/17/2024 through 06/27/24 (11doses). CC1 stated they believed the omissions of clonazepam resulted in Resident 2 falling and hitting their head; and calling CC1 at midnight because the resident had increased anxiety. CC1 stated they were concerned the sudden stop and omissions of the clonazepam could have resulted in Resident 2 having withdrawal symptoms, such as seizures. CC1 further stated the facility should have notified them when the facility ran out of the clonazepam because they could have obtained a refill of it quickly.

Observation On 07/05/2024 at 5:00 PM, showed Resident 2 resided in an adult family home, after being discharged from the facility. The resident was observed quietly seated in a wheelchair. The resident was observed with a one-inch, round abrasion on top of their head that they stated was from a recent fall when they resided in the assisted-living facility.

In an interview on 07/05/2024 at 5:00 PM, Resident 2 stated the facility recently omitted several doses of clonazepam because the facility did not refill their medication in a time, which resulted in medication omissions. The resident stated they had felt "awful," "sick," "weak," and "shaky" as the result of the missed clonazepam, adding, "I thought I was going to die." The resident stated they fell in the assisted-living facility during the time of the clonazepam omissions and sustained the wound on their head. Regarding the clonazepam omissions, Resident 2 stated, "it was so frightening" and further stated they felt "frustrated," "angry," and "scared."

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In an interview on 07/25/2024 at 5:10 PM, Staff F, Medication Aide, stated they were aware that the facility sometimes ran out of residents' medications. Staff F stated that when needed medications needed to be refilled in the facility, the medication aide should contact the pharmacy and could call the resident's family. Staff F further stated medication refills should be obtained when eight days-worth of medications remained in the facility.

In an interview on 07/26/2024 at 11:47 AM, Staff E, Medication Aide, stated they recalled the facility ran out of Resident 2's clonazepam in mid-June 2024. Regarding the facility's procedures for obtaining medication refills, Staff E stated they were trained by former staff who didn't provide them with "in depth" training regarding the facility's process for refills.

In an interview on 08/12/2024 at 9:50 AM, Staff C, Resident Care Coordinator, stated they did not know about omissions of Resident 2's clonazepam. Staff C stated Staff B, Health and Wellness Director, or Staff D, Resident Care Coordinator (RCC), or a medication aide that no longer worked in the facility would know details about the clonazepam omissions. Regarding procedures for medication refills, Staff C stated medication aides should call the pharmacy when the supply available was down to the last seven days.

In an interview on 08/12/2024 at 10:25 AM, Staff G, Medication Aide, stated when a resident's medication(s) were not available, the medication aides needed to inform Staff C or Staff D, make a note in Resident Notes, call or fax the pharmacy who would let the facility know when the medication(s) would be refilled, and communicate verbally or via notes with the on-coming shift. Staff G stated the medication aides alerted an RCC or Staff B who would address the problem. Staff G stated they had only been working in the facility for two or three months and did not receive training regarding obtaining medication refills.

In an interview on 08/13/2024 at 10:50 AM, Staff B stated staff placed several calls to the prescriber that ordered Resident 2's clonazepam, and the pharmacy but did not get responses. Staff B stated any attempts by staff to reach the prescriber or pharmacy was documented in the Resident Progress Notes. Staff B stated they were unsure if Resident 2's family was notified about the clonazepam needing to be refilled. Staff B stated when the prescriber did not respond, the facility switched to a different prescriber who Staff B was familiar with and they estimated a refill of the clonazepam was obtained when the switch was made. Staff B was unsure when the change of prescriber was made.

Review of Resident Notes for Resident 2, dated 06/24/2024 at 12:22 AM, showed Staff E faxed the prescriber asking for an urgent refill of the clonazepam (seven days after the supply of the medication was unavailable).

In an interview on 07/25/2024 at 5:10 PM, Staff F, Medication Aide, stated they were aware that the facility sometimes ran out of residents' medications. Staff F stated that when needed medications needed to be refilled in the facility, the medication aide should contact the pharmacy and could call the resident's family. Staff F further stated medication refills should be obtained when eight days-worth of medications remained in the facility.

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Statement of Deficiencies	License #: 2479	Compliance Determination # 44863
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 5 of 5	Licensee: PSL Associates, LLC	08/27/2024

Review of Resident Notes for Resident 2, dated 06/27/2024 at 1:07 PM, showed Staff H, Medication Aide, called the pharmacy at 9:55 AM that day to follow up on the unavailable clonazepam (eleven days after the supply of the medication was unavailable).

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) 10/11/24 .

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

Administrator (or Representative) — Date: 9/12/24

Review of Resident Notes for Resident 2, dated 06/27/2024 at 1:07 PM, showed Staff H, Medication Aide, called the pharmacy at 9:55 AM that day to follow up on the unavailable clonazepam (eleven days after the supply of the medication was unavailable).

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