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) 49785 (Completion Date 11/04/2024) and 47306 (Completion Date 09/13/2024).

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-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

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: 145558
Compliance Determination #: 47306
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sylvia Shauvin
Investigation Date(s): 09/04/2024 through 09/13/2024
Complainant Contact Date(s):

Allegation(s):

1 - Staff that tested positive for Covid 19 and were symptomatic were forced to work

Investigation Methods:

Sample:	Total residents: 99 Resident sample size: 4 Closed records sample size: 0
Observations:	Any residents and staff with symptoms of illness Facility's infection control practices e.g. hand-washing, prevention of cross-contamination/spread of infection
Interviews:	Seven caregivers Two Medication Aides Memory Care Director Activities Coordinator Health and Wellness Director Administrator
Record Reviews:	Staffing schedules - July and August 2024 Facility's Infection Control policies and procedures

Investigation Summary:

1 - During unannounced visits to the facility, residents and staff were observed without symptoms of illness. In interviews with line staff, such as caregivers, medication aides, and activities staff, they stated during the months of July and August 2024, staff felt pressure to work when they had symptoms of respiratory illness (e.g. coughing, sneezing, runny nose) because the facility was inadequately staffed. Six staff were observed not washing their hands after providing care to residents or handling soiled items. Failed facility practices were found and documented in a Statement of Deficiencies under Washington Administrative Code 388-78a-2610(1)(2)(a)(d)(e) Infection Control.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2479	Compliance Determination # 47306
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 1 of 5	Licensee: PSL Associates, LLC	09/13/2024

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 09/04/2024, 09/04/2024, 09/13/2024 and 09/13/2024 of:

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

This document references the following complaint number(s): 145558

The following sample was selected for review during the unannounced on-site visit: 4 of 99 current residents and 0 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.

J Salguist — 09/23/2024
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.

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 09/04/2024, 09/04/2024, 09/13/2024 and 09/13/2024 of:

North Point Village, Assisted Living & Memory Care
1110 E Westview Ct
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Sylvia Shauvin, Complaint Investigator

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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 # 47306
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 2 of 5	Licensee: PSL Associates, LLC	09/13/2024

Administrator (or Representative)

9/25/24
Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure staff practiced hand hygiene for 6 of 6 staff (Staff E, F, G, K, M, and O) and failed to ensure staff did not provide resident care while they experienced symptoms of respiratory illness for7 of 7 staff (Staff C, D, E, F, G, K, and L). This failure placed residents at risk for the spread of infection among residents and staff and placed residents at risk of exposure to an infectious illness.

Findings included...

Lack of hand hygiene

Review of the facility's policy titled, "Infection Control," dated July 2020, showed the staff should use gloves when providing care to residents; and wash their hands between glove changes, after providing care to residents, and when leaving residents' apartments.

Observation on 09/13/2024 at 10:15 AM, showed Staff G, Caregiver, disposed of a bag of trash containing used incontinence care products, such as briefs. Further observation showed Staff G did not wash their hands after disposing of the trash.

Observation on 09/13/2024 at 10:25 AM, showed Staff E, Caregiver, provided incontinence care and a brief change for Resident 1. Staff E and Staff M, Caregiver, were observed assisting Resident 1 with dressing, and a transfer from bed to a wheelchair using a Hoyer lift. Staff E and Staff M were observed wearing gloves to assist the resident with dressing but did not wash their hands after removing their gloves. Further observation showed Staff E provided the resident with physical assistance to brush their teeth.

Observation on 09/13/2024 at 11:35 AM, showed Staff M, Caregiver, assisted Resident 2

Administrator (or Representative) Date

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(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure staff practiced hand hygiene for 6 of 6 staff (Staff E, F, G, K, M, and O) and failed to ensure staff did not provide resident care while they experienced symptoms of respiratory illness for7 of 7 staff (Staff C, D, E, F, G, K, and L). This failure placed residents at risk for the spread of infection among residents and staff and placed residents at risk of exposure to an infectious illness.

Findings included…

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Review of the facility's policy titled, "Infection Control," dated July 2020, showed the staff should use gloves when providing care to residents; and wash their hands between glove changes, after providing care to residents, and when leaving residents' apartments.

Observation on 09/13/2024 at 10:15 AM, showed Staff G, Caregiver, disposed of a bag of trash containing used incontinence care products, such as briefs. Further observation showed Staff G did not wash their hands after disposing of the trash.

Observation on 09/13/2024 at 10:25 AM, showed Staff E, Caregiver, provided incontinence care and a brief change for Resident 1. Staff E and Staff M, Caregiver, were observed assisting Resident 1 with dressing, and a transfer from bed to a wheelchair using a Hoyer lift. Staff E and Staff M were observed wearing gloves to assist the resident with dressing but did not wash their hands after removing their gloves. Further observation showed Staff E provided the resident with physical assistance to brush their teeth.

Observation on 09/13/2024 at 11:35 AM, showed Staff M, Caregiver, assisted Resident 2

with a transfer out of bed and brushed the resident's hair. Further observation showed that Staff M did not wash their hands afterwards, then proceeded to set up beverages for lunch.

Observation on 09/13/2024 at 11:50 AM, showed Staff K, Caregiver, assisted Resident 3 to put on shoes. Further observation showed Staff K did not wash their hands after assisting Resident 3 and proceeded to assist residents with lunch in the dining room.

Observation on 09/13/2024 at 2:00 PM, showed Staff O, Caregiver, and Staff F, Caregiver, assisted Resident 4 with a transfer from bed to their wheelchair using a Hoyer lift. Observation showed that Staff O and F did wear gloves. Observation showed that Staff F checked the resident's brief to see if it needed to be changed, checked under the gauze on the resident's legs without gloves, then applied boots to the resident's feet. Further observation showed that Staff O and Staff F did not wash their hands after they assisted the resident.

In an interview on 09/13/2024 at 2:50 PM, Staff B, Health and Wellness Director, stated staff should wash their hands after providing any care to residents, taking residents to the bathroom, and handling soiled items.

Staff reporting to work while ill

Review of the facility's July 2024 staff schedule showed Staff C, Medication Aide, worked on 07/30/2024, and 07/31/2024.

Review of the facility's August 2024 staff schedule showed Staff C worked on 08/01/2024.

Review of the facility's July 2024 staff schedule showed Staff D, Medication Aide, worked on 07/28/2024, 07/29/2024, 07/30/2024, and 07/31/2024.

Review of the facility's July 2024 staff schedule showed Staff E, worked on 07/29/2024, 07/30/2024, and 07/31/2024.

Review of the facility's August 2024 staff schedule showed Staff E worked on 08/01/2024 and 08/02/2024.

Review of the facility's July 2024 staff schedule showed Staff G worked on 07/29/2024, 07/30/2024, and 07/31/2024.

Review of the facility's August 2024 schedule showed Staff G worked on 08/01/2024.

In an interview on 08/30/2024 at 10:54 AM, Staff H, Memory Care Director, stated Staff C recently tested positive for Covid 19 on 07/28/2024, called in ill on 07/29/2024, and returned to work the following day 07/30/2024. Staff H stated when Staff C reported to work on Tuesday, Staff C complained about feeling ill, but was concerned there was no one to cover their shift. Staff H further stated they spoke to Staff A, Administrator, regarding Staff C 's illness and Staff A told them Staff C could work because the facility was experiencing "critical staffing" status. Staff H was concerned about Staff C working while ill because Staff C provided care to residents in all three cottages which

with a transfer out of bed and brushed the resident's hair. Further observation showed that Staff M did not wash their hands afterwards, then proceeded to set up beverages for lunch.

Observation on 09/13/2024 at 11:50 AM, showed Staff K, Caregiver, assisted Resident 3 to put on shoes. Further observation showed Staff K did not wash their hands after assisting Resident 3 and proceeded to assist residents with lunch in the dining room.

Observation on 09/13/2024 at 2:00 PM, showed Staff O, Caregiver, and Staff F, Caregiver, assisted Resident 4 with a transfer from bed to their wheelchair using a Hoyer lift. Observation showed that Staff O and F did wear gloves. Observation showed that Staff F checked the resident's brief to see if it needed to be changed, checked under the gauze on the resident's legs without gloves, then applied boots to the resident's feet. Further observation showed that Staff O and Staff F did not wash their hands after they assisted the resident.

In an interview on 09/13/2024 at 2:50 PM, Staff B, Health and Wellness Director, stated staff should wash their hands after providing any care to residents, taking residents to the bathroom, and handling soiled items.

Staff reporting to work while ill

Review of the facility's July 2024 staff schedule showed Staff C, Medication Aide, worked on 07/30/2024, and 07/31/2024.

Review of the facility's August 2024 staff schedule showed Staff C worked on 08/01/2024.

Review of the facility's July 2024 staff schedule showed Staff D, Medication Aide, worked on 07/28/2024, 07/29/2024, 07/30/2024, and 07/31/2024.

Review of the facility's July 2024 staff schedule showed Staff E, worked on 07/29/2024, 07/30/2024, and 07/31/2024.

Review of the facility's August 2024 staff schedule showed Staff E worked on 08/01/2024 and 08/02/2024.

Review of the facility's July 2024 staff schedule showed Staff G worked on 07/29/2024, 07/30/2024, and 07/31/2024.

Review of the facility's August 2024 schedule showed Staff G worked on 08/01/2024.

In an interview on 08/30/2024 at 10:54 AM, Staff H, Memory Care Director, stated Staff C recently tested positive for Covid 19 on 07/28/2024, called in ill on 07/29/2024, and returned to work the following day 07/30/2024. Staff H stated when Staff C reported to work on Tuesday, Staff C complained about feeling ill, but was concerned there was no one to cover their shift. Staff H further stated they spoke to Staff A, Administrator, regarding Staff C 's illness and Staff A told them Staff C could work because the facility was experiencing "critical staffing" status. Staff H was concerned about Staff C working while ill because Staff C provided care to residents in all three cottages which

potentially resulted in the spread of infection.

In an interview on 09/05/2024 at 12:45 PM, Staff C stated since 07/04/2024, they experienced ongoing symptoms related to bronchitis (an infection/inflammation of the lungs) that included a cough and fever of 99 degrees Fahrenheit (normal body temperature is 98.6 degrees Fahrenheit). Staff C stated when they re-tested on 08/04/2024, the results were positive. Staff C stated they called Staff I, Resident Care Coordinator (RCC), who asked Staff C to report to work on 08/05/2024 to re-test for Covid 19. Staff C stated they did not report to work on 08/05/2024 as they felt ill, then reported to work on 08/06/2024 at which time they continued to test positive for Covid 19 and had a cough. Staff C stated they decided to remain at work because the facility did not have enough staff to cover their shift in the three cottages. Staff C stated other staff such as Staff E, Staff F, Caregiver, Staff D, and Staff G also worked when they tested positive for Covid 19 and had symptoms, such as coughing. Staff C stated they were "unsure" about the facility's written policy regarding staff reporting to work while ill. Staff C stated staff were told they could report to work while ill if 50 percent of the residents were ill. Staff C further stated they heard this from several other staff adding, "That's how things work (facility practice regarding infection control) in the cottages. Staff C stated hearing "through the grapevine" among staff that Staff B Staff I and Staff J, Resident Care Coordinator, provided the instruction that staff could report to work when they were ill.

In an interview on 09/05/2024 at 2:30 PM, Staff D stated they had an ongoing cough and fatigue related to pneumonia (a lung infection), during the months of July 2024 and August 2024. Staff D stated Staff B and Staff J advised them to report for work several times during this period, even though they felt ill with symptoms such as coughing, sneezing, runny nose, congestion, and body aches. Staff D further stated Staff B and Staff J advised staff during this period that they could report to work while positive for Covid 19/symptomatic when 50 percent or more of the residents were also ill.

In an interview on 09/13/2024 at 11:15 AM, Staff E stated they tested positive for Covid 19 around the end of July 2024 and beginning of August 2024 and reported for work. Staff E stated Staff A and Staff B informed staff they could work while ill because all the residents in Cottage C were positive for Covid 19, so staff couldn't make the residents ill. Regarding the facility's written policy regarding staff reporting to work when they were ill, Staff C couldn't recall the specifics.

In an interview on 09/13/2024 at 11:50 AM, Staff K stated they worked when they tested positive for Covid 19 in late July 2024 and early August 2024. Staff K stated all the residents in Cottage A were ill with Covid 19 and Staff B and Staff J told staff they could report to work while ill because all the residents were also ill.

In an interview on 09/13/2024 at 12:25 PM, Staff L, Medication Aide, stated only one resident in Cottage B was ill during the period of late July 2024 and early August 2024 when many staff that worked in all three cottages were ill with Covid 19. Staff L stated they did not get Covid 19 but was concerned that ill staff helped with care of residents in each cottage, which could result in the spread of infection. Staff L stated the discretion about whether to report for work or not while ill was left up to staff.

In an interview on 09/13/2024 at 12:45 PM Staff F stated several caregivers felt pressure from facility managers to work while ill, or worked with symptoms, such as coughing. Staff F stated they did not test positive for Covid 19 but assisted with

potentially resulted in the spread of infection.

In an interview on 09/05/2024 at 12:45 PM, Staff C stated since 07/04/2024, they experienced ongoing symptoms related to bronchitis (an infection/inflammation of the lungs) that included a cough and fever of 99 degrees Fahrenheit (normal body temperature is 98.6 degrees Fahrenheit). Staff C stated when they re-tested on 08/04/2024, the results were positive. Staff C stated they called Staff I, Resident Care Coordinator (RCC), who asked Staff C to report to work on 08/05/2024 to re-test for Covid 19. Staff C stated they did not report to work on 08/05/2024 as they felt ill, then reported to work on 08/06/2024 at which time they continued to test positive for Covid 19 and had a cough. Staff C stated they decided to remain at work because the facility did not have enough staff to cover their shift in the three cottages. Staff C stated other staff such as Staff E, Staff F, Caregiver, Staff D, and Staff G also worked when they tested positive for Covid 19 and had symptoms, such as coughing. Staff C stated they were “unsure” about the facility’s written policy regarding staff reporting to work while ill. Staff C stated staff were told they could report to work while ill if 50 percent of the residents were ill. Staff C further stated they heard this from several other staff adding, “That’s how things work (facility practice regarding infection control) in the cottages. Staff C stated hearing “through the grapevine” among staff that Staff B Staff I and Staff J, Resident Care Coordinator, provided the instruction that staff could report to work when they were ill.

In an interview on 09/05/2024 at 2:30 PM, Staff D stated they had an ongoing cough and fatigue related to pneumonia (a lung infection), during the months of July 2024 and August 2024. Staff D stated Staff B and Staff J advised them to report for work several times during this period, even though they felt ill with symptoms such as coughing, sneezing, runny nose, congestion, and body aches. Staff D further stated Staff B and Staff J advised staff during this period that they could report to work while positive for Covid 19/symptomatic when 50 percent or more of the residents were also ill.

In an interview on 09/13/2024 at 11:15 AM, Staff E stated they tested positive for Covid 19 around the end of July 2024 and beginning of August 2024 and reported for work. Staff E stated Staff A and Staff B informed staff they could work while ill because all the residents in Cottage C were positive for Covid 19, so staff couldn’t make the residents ill. Regarding the facility’s written policy regarding staff reporting to work when they were ill, Staff C couldn’t recall the specifics.

In an interview on 09/13/2024 at 11:50 AM, Staff K stated they worked when they tested positive for Covid 19 in late July 2024 and early August 2024. Staff K stated all the residents in Cottage A were ill with Covid 19 and Staff B and Staff J told staff they could report to work while ill because all the residents were also ill.

In an interview on 09/13/2024 at 12:25 PM, Staff L, Medication Aide, stated only one resident in Cottage B was ill during the period of late July 2024 and early August 2024 when many staff that worked in all three cottages were ill with Covid 19. Staff L stated they did not get Covid 19 but was concerned that ill staff helped with care of residents in each cottage, which could result in the spread of infection. Staff L stated the discretion about whether to report for work or not while ill was left up to staff.

In an interview on 09/13/2024 at 12:45 PM Staff F stated several caregivers felt pressure from facility managers to work while ill, or worked with symptoms, such as coughing. Staff F stated they did not test positive for Covid 19 but assisted with

residents' care in each cottage, as needed, potentially resulting in the spread of infection.

In an interview on 09/13/2024 at 2:00 PM, Staff N, Activities Coordinator, stated they observed several staff reporting to work and working in the different cottages while having symptoms of Covid 19 because the facility did not have enough staff. Staff N further stated they were concerned this practice placed residents who were well, at risk of becoming ill.

In an interview on 09/13/2024 at 2:50 PM, Staff A stated if staff were in the facility and tested positive for Covid 19, they were sent home. Staff A stated that when the facility experienced a staffing shortage, staff were allowed to report to work if they were free of infection symptoms.

In an interview on 09/13/2024 at 2:50 PM, Staff B stated the Local Health Jurisdiction provided the facility with guidance about staff reporting to work during Covid 19 outbreaks in the facility. Staff B stated that staff that tested positive for Covid 19 should stay home for a minimum of five days and if they did not have a fever or their symptoms improved, they could return to work in 48 hours, and wear a mask and eye protection while providing care to residents. Staff B stated staff were expected to go home if they had a fever and come into the facility on days one, three, five, and seven to test for Covid 19. Staff B stated staff were not expected to report to work when they had infection symptoms.

Review of the facility's policy titled, "Infection Control," dated July 2020, showed the Administrator and/or Administrator Designee should monitor staff showing symptoms of infection and arrange appropriate coverage for residents' and staffs' safety. Further review of the policy showed no guidance that staff who were ill could return to work if over 50 percent of the residents were ill.

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) 10/28/24.

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

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

residents' care in each cottage, as needed, potentially resulting in the spread of infection.

In an interview on 09/13/2024 at 2:00 PM, Staff N, Activities Coordinator, stated they observed several staff reporting to work and working in the different cottages while having symptoms of Covid 19 because the facility did not have enough staff. Staff N further stated they were concerned this practice placed residents who were well, at risk of becoming ill.

In an interview on 09/13/2024 at 2:50 PM, Staff A stated if staff were in the facility and tested positive for Covid 19, they were sent home. Staff A stated that when the facility experienced a staffing shortage, staff were allowed to report to work if they were free of infection symptoms.

In an interview on 09/13/2024 at 2:50 PM, Staff B stated the Local Health Jurisdiction provided the facility with guidance about staff reporting to work during Covid 19 outbreaks in the facility. Staff B stated that staff that tested positive for Covid 19 should stay home for a minimum of five days and if they did not have a fever or their symptoms improved, they could return to work in 48 hours, and wear a mask and eye protection while providing care to residents. Staff B stated staff were expected to go home if they had a fever and come into the facility on days one, three, five, and seven to test for Covid 19. Staff B stated staff were not expected to report to work when they had infection symptoms.

Review of the facility's policy titled, "Infection Control," dated July 2020, showed the Administrator and/or Administrator Designee should monitor staff showing symptoms of infection and arrange appropriate coverage for residents' and staffs' safety. Further review of the policy showed no guidance that staff who were ill could return to work if over 50 percent of the residents were ill.

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