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

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 License # 2479

Dear Administrator:

This letter addresses Compliance Determination(s) 50906 (Completion Date 11/22/2024) and 46341 (Completion Date 09/26/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/22/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2300-2-a-i, WAC 388-78A-2450-1-a, WAC 388-78A-2450-1-b, WAC 388-78A-2450-2-e

The Department staff who did the on-site verification:
Joy Pipgras, LTC Surveyor

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

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: 145301
Compliance Determination #: 46341
Region/Unit #: RCS Region 1 / Unit B
Investigator: Joy Pipgras
Investigation Date(s): 08/28/2024 through 09/26/2024
Complainant Contact Date(s):

Allegation(s):
A resident choked and had to go to the hospital.

Investigation Methods:

Sample:	Total residents: 109 Resident sample size: 7 Closed records sample size: 0
Observations:	Resident Saftety/well-being meals/food textures appropriate Staff feeding/interactions Proper positioning Adaptive equipment Set up of food/texture
Interviews:	Resident/Rep interviews Choking history Need for modified texture Hospitalization needed, any DC instructions Staff interviews: Dietary instructions/kitchen procedures Instruction on feeding/ written/verbal
Record Reviews:	Hospital Records Dr. Orders Care Plan Assessment Policy or procedure Facility investigation

Investigation Summary:
A resident began to choke during dinner service. Facility staff could not get food lodged from the named resident's throat and called 911. The resident was admitted to the hospital. Investigation showed that the resident received a pureed diet and received a meal that had chucks of meat that had not been pureed. Dietary staff did

not ensure the food was prepared as ordered and the care staff assisting the resident with eating did not ensure the food was the proper texture and safe for the resident to eat. Deficient practice identified under WAC 2300 388-78A-2300 (2) (a) (i)

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: 145646
Compliance Determination #: 46341
Region/Unit #: RCS Region 1 / Unit B
Investigator: Joy Pipgras
Investigation Date(s): 08/28/2024 through 09/26/2024
Complainant Contact Date(s):

Allegation(s):
Resident was given hot liquid and received second degree burns.

Investigation Methods:

Sample:	Total residents: 109 Resident sample size: 7 Closed records sample size: 0
Observations:	Residents surroundings Staff to Resident ratio Staff to Resident interactions Warning labels/signage related to food and drink temperatures Staff food and beverage service
Interviews:	Residents Staff Resident's POA
Record Reviews:	Face Sheet MARs Care Plans Progress Notes Incident report and investigations Dr. Orders

Investigation Summary:
The named resident was served hot chocolate that had an initial temperature of 170 degrees. Staff did not wait for the beverage to cool and gave it the memory care resident. The resident spilled the beverage and received 2nd degree burns on their inner and back thighs. There was no signage or warnings about the hot water dispenser. Staff did not cool the beverage before serving it. A facility investigation was done. No training on proper temperatures for service was completed prior to event. Staff providing care and services had not received specialty training for dementia. Deficient practice identified under WAC Staff 388-78A-2450 (1) (b)

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 # 46341
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 1 of 12	Licensee: PSL Associates, LLC	09/26/2024

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 08/28/2024, 08/29/2024, 08/30/2024, 09/04/2024, 09/05/2024, 09/06/2024 and 09/09/2024 of:

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

This document references the following complaint number(s): 144597, 145301, 145646

The following sample was selected for review during the unannounced on-site visit: 7 of 109 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

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: 10/10/2024

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) 10/16/24 Date

WAC 388-78A-2300 Food and nutrition services.

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure resident specialty diets were served per a diet manual and as ordered for 7 of 7 sampled residents (Resident 1, 2, 3, 4, 5, 6, and 7) and failed to have a diet manual available for food preparation. These failures resulted in a choking episode with aspiration for Resident 1, contradictory diet service for Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7, and placed residents at risk for unmet dietary needs and preferences and health complications.

Findings included...

Review of the facility's Disclosure of Services showed the facility provided pureed (foods that require no chewing) and mechanical soft diets (food that require little chewing or break apart easily).

Review of the facility's policy titled, "Food Therapeutic Diets," dated 01/01/2022, showed:

-Ensure all Dining Services Associates know the diet ordered for the resident.

-If a change in a resident's diet is made, a new dietary order should be completed by the ED (Executive Director) or WD (Wellness Director) and given to the DSD (Dietary Services Director).

-All special diets should be followed. If further assistance is needed in determining what to serve the resident, notify the WD and or ED and they can contact the Region Director for further assistance from the dietitian as required.

<Resident 1>

Review of Resident 1's Face Sheet showed the resident was admitted to the facility's memory care (specialized care for older adults with memory and cognitive loss) on [redacted]/2020 and had a diagnosis of [redacted] ([redacted]) and [redacted] ([redacted]) and received a pureed diet.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 08/25/2024, showed that Resident 1 was to receive a pureed diet and needed full staff assistance with eating.

Observation on 08/30/2024 at 12:05 PM, showed Resident 1 coughed while they received eating assistance from Staff A, Caregiver.

Review of Resident 1's progress note, dated 08/30/2024, showed documentation by Staff B, Medication Technician, that during dinner service on that day Resident 1 had coughed up a chunk of meat the size of a quarter and appeared to aspirate (food or liquid breathed into the lungs). Further review of the progress note showed that Resident 1 was red in the face, had mucous draining from their nose and coughed with shallow breaths. The progress notes showed that paramedics were called and upon arrival confirmed that Resident 1 had aspirated and that their oxygen was at 70 percent (normal level measuring between 95 and 100 percent). The note further showed that Resident 1 was taken to the hospital via ambulance.

Review of Resident 1's progress note, dated 09/01/2024, showed documentation by Staff C, Health and Wellness Specialist, that Resident 1 had been admitted to the hospital for hypoxia (not enough oxygen) and aspiration.

In an interview on 09/04/2024 at 2:20 PM Staff C, Cook, confirmed that they had prepared the pureed food for Resident 1 and "might not have noticed" any large pieces of food. Staff C stated that the pureed food should have been thin enough to drink through a straw.

In an interview on 09/05/2024 at 1:40 PM, Staff D, Caregiver, stated that Resident 1 would choke on "chunks" of food. Staff D stated that Resident 1 was dependent on staff for feeding and diet assistance.

In an interview on 09/05/2024 at 3:00 PM, Collateral Contact 1(CC1), Resident Representative, stated that Resident 1 had been on a pureed diet for two years and had a history of choking.

<Resident 2>

Review of Resident 2's Face Sheet showed the resident admitted to the facility's memory care on [redacted]/2024 and had a diagnosis of [redacted] ([redacted]) and [redacted] and received a mechanical soft diet.

Review of Resident 2's NSA, dated 06/30/2024, showed that Resident 2 was on a general mechanical soft diet and was at risk for aspiration.

Observation on 08/29/2024 at 11: 50 AM, showed Resident 2 with a meal consisting of chicken strips, fries, pickled beets and soup. Further observation showed that Resident 2's chicken was cut in half inch pieces, the fries were left whole, and the beets were left in full slices.

In an interview on 08/29/2024 at 11:52 AM, with Staff F, Caregiver, was asked why they had to cut the resident's food up, Staff F stated that Resident 2 was on a mechanical soft diet. Staff F was asked by the department investigator why dietary services (kitchen staff) had not prepared (cut up to appropriate consistency) the mechanical soft diet, Staff F responded, "I don't know, we just usually have to do it." When asked if they knew what the consistency of a mechanical diet was, Staff F stated, "not really."

Review of a Resident 2'a Vitals Report showed that Resident 2 had gone from [redacted] pounds (lbs.) on 08/02/2024 to [redacted] lbs. on 08/29/2024, a loss of 14 lbs.

In an interview on 09/03/2024 at 12:16 PM Collateral Contact 2 (CC2), Resident Representative, stated they were concerned about Resident 2's weight loss and had left messages with no return from the nursing staff.

<Resident 3>

Review of Resident 3's Face Sheet showed they admitted to the facility's memory care on [redacted]/2024 and was on a mechanical soft diet.

Review of Resident 3's NSA, dated 08/30/2024, showed that Resident 3 was diagnosed with [redacted], [redacted], [redacted] and [redacted]. Further review showed that Resident 3 was on a mechanical soft diet and required one person assist with cutting up food and required a "hand over hand technique" to start them eating (staff places hand on utensil and then places their hand over the resident's hand to direct food onto the

utensil and then to the mouth). The NSA showed that if Resident 3 did not continue the "hand over hand technique" staff were to assist them with eating.

Review of Resident 3's progress note, dated 08/13/2024, showed that Resident 3's diet was changed to mechanical soft, and that the kitchen had been notified.

In an interview on 09/04/2024 at 2:20 PM, Staff C stated that Resident 3 had a dietary order for no red meat. Staff C stated they were not aware of Resident 3's mechanical soft diet.

Observation on 08/29/2024 at 2:24 PM showed Resident 3's name was not on the special diet list in the kitchen and was not served a mechanical soft diet.

<Resident 4>

Review of Resident 4's Face Sheet showed they resident admitted to the facility's memory care on [redacted]/2023 with a diagnosis of [redacted] and [redacted].

Review of Resident 4's NSA, dated 07/20/2024, showed that Resident 4 "will receive diet as ordered," was on a general mechanical soft diet, and required assistance with eating during each meal.

In an interview on 08/29/2024 at 11:10 AM, Staff B, Medication Technician, stated that Resident 4 consistently had not received mechanical soft meals from the kitchen and that care staff had to cut up the resident's meat.

In an interview on at 08/29/2024 at 2:20 PM, Staff H, Cook, stated that they were "too busy" or "just forgot" to prepare the mechanical soft diets.

<Resident 5>

Review of Resident 5's Face Sheet showed the resident admitted on [redacted]/2014 with a diagnosis of [redacted] and [redacted].

Review of undated physician diet orders showed that Resident 5 was to receive a regular diet with no restrictions.

Observation on 08/29/2024 at 12:08 PM showed Resident 5's chicken strips were cut in half inch pieces.

Review of Resident 5's NSA, dated 07/07/2024, showed that Resident 5 was on a regular diet without restrictions.

In an interview on 09/04/2024 at 2:20 PM, Staff C stated that Resident 5 had a dietary order for mechanical soft. Staff C stated they were not aware that Resident 5 was on a regular diet.

<Resident 6>

Review of Resident 6's Face Sheet showed the resident admitted to the facility on [redacted]/2017 with a diagnosis of [redacted] and [redacted].

Review of Resident 6's NSA, dated 06/22/2024, showed that Resident 6 was on a low salt regular diet without restrictions.

Review of Resident 6's physician diet orders showed that Resident 6 was to receive a no-added salt regular diet.

Observation on 08/29/2024 at 12:05 PM, showed Resident 6's chicken was cut up by staff in half inch pieces.

Review of the facility' diet list in the kitchenette showed the resident was on a mechanical soft diet.

In an interview on 09/04/2024 at 2:20 PM, Staff C stated that Resident 6 had a dietary order for mechanical soft. Staff C stated they were not aware that Resident 6 was on a regular no salt diet.

<Resident 7>

Review of Resident 7's Face Sheet showed the resident admitted to the facility on [redacted]/2024 and was diagnosed with [redacted] and [redacted] ([redacted]).

Review of Resident 7's NSA, dated 08/01/2024, showed that Resident 7 was on a regular diet without restrictions.

Review of Resident 7's physician orders showed that Resident 7 was to receive a regular diet.

Observation on 08/29/2024 at 11: 58 AM, showed Resident 7's lunch item of chicken strips was cut up by staff in half inch pieces.

In an interview on 09/04/2024 at 2:20 PM, Staff C stated that Resident 7 had a dietary order for mechanical soft. Staff C stated they were not aware that Resident 7 was on a regular diet.

In an interview on 08/30/2024 at 3:14 PM Staff J, Executive Director and Staff G, Health and Wellness Specialist, both stated they were not aware of the confusion with the diet orders and did not know why residents had not received their diets as ordered. Staff J further stated that they needed to follow-up with staff and that they "needed a better system."

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) 11/8/24

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

Administrator (or Representative) — Date: 10/16/24

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

(b) Maintain the assisted living facility free of safety hazards; and

(2) The assisted living facility must:

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure staff maintained a safe environment for 1 of 1 resident (Resident 7), failed to provide required and necessary training to 1 of 1 staff (Staff I) and failed to ensure staff provided care identified in negotiated service agreements for 3 of 3 residents (Resident 2, 7, and 8). These failures contributed to a second degree burn to Resident 7, a fall with injury for Resident 8, unmet shower needs for Resident 2 and Resident 7, and placed residents at risk of having unmet care needs and injury.

Findings included..

<Safe environment>

Review of Resident 7's Face Sheet showed the resident admitted to the facility on [redacted]/2024 and was diagnosed with [redacted] ([redacted]) and [redacted] ([redacted]).

Review of Resident 7's progress note written by Staff G, Health and Wellness Specialist, showed that on 08/31/2024 at 10:30 AM, Resident 7 was given hot chocolate, spilled it on their lap and received second degree burns (skin injury/burn that affects the second layer of skin). The progress note showed that Staff E, Caregiver, checked Resident 7's upper thigh after the incident and stated they "didn't see any redness." The progress note showed that at 1:00 PM, caregivers assisted resident with a brief change and found redness on Resident 7's inner thigh. The note showed that at 8:15 PM staff observed that Resident 7 had two fluid filled areas (blisters) on the back portion of the right thigh, one fluid filled area in the middle of the right thigh, and one fluid filled area located on the middle portion of the left thigh.

Review of an interview document, written by Staff G, showed that Staff E took the hot chocolate to the resident and told them it was hot and that Resident 7 "has always been good about allowing the hot chocolate to cool down." The document showed that Staff E always used the hot water from the coffee maker.

Review of a facility investigation, dated 09/05/2024, showed that the hot water from the dispenser measured 170 degrees Fahrenheit (F) directly from the dispenser and 164 F five minutes later.

In an interview on 09/04/2025 at 3:23 PM, Staff G stated that Staff E did not temperature check the hot chocolate prior to serving it to Resident 7. Staff G stated that the caregivers, including Staff E, needed training on appropriate liquid temperatures and dementia training prior to working on the memory care unit.

Observation on 09/06/2024 showed no warning label on the hot water dispenser or warning signage in any of the three memory care kitchenettes.

<Training>

Review of the facility's Care Partner Job Description, dated 03/2024, showed Essential Duties to be the following:

-Interacts with residents, guests and staff in an atmosphere of hospitality.

-Demonstrated ability to communicate effectively "in English", both verbally and in writing with residents and staff.

-Ability to follow all policies and procedures.

-Read the staff communication records and maintain familiarity with Resident records as required.

Review of the facility's undated staff list showed that Staff I was hired on 07/24/2024 as a caregiver for the memory care unit.

Observation on 08/29/2024 at 11:57 AM, showed Staff I, Caregiver, passed lunch plates to residents. Further observation showed that Staff I had to ask other staff to assist them with residents' names and did not verbally interact with residents.

In an interview, with the use of a translation application, on 08/30/2024 at 1:38 PM, Staff I, stated that they did not know all the resident's names or the names of their coworkers. Staff I stated they did not know where to find care plans.

In an interview on 09/03/2024 at 1:28 PM, Staff E, Caregiver, stated they were assigned to train Staff I and that the translator application had not worked to communicate with many of the residents. Staff E further stated they had not realized that the language barrier would be so difficult in training Staff I and that Staff I did not understand how to "handle dementia residents or deescalate them when aggressive," had a poor approach with the residents and that Staff I had been hit and spit on by residents.

In an interview on 09/09/2024 at 1:44 PM, Staff G and Staff J, Executive Director, stated they were not aware of Staff I's primary language and had not provided care plans for Staff I in their native language. Staff J and Staff G both confirmed that staff, including Staff I, did not get required training prior to working in the memory care unit.

<Provision of care>

Resident 2

Review of Resident 2's Face Sheet showed they admitted to the facility's memory care on [redacted]/2024.

Review of Resident 2's NSA, dated 06/30/2024, showed the resident required one staff assistance with showers two times a week.

In an interview on 09/03/2024 at 12:16 PM Collateral Contact 2 (CC2), Resident Representative, stated that the resident had not been showered in over a month.

Review of Resident 2's August 2024 electronic Resident Monthly Assignment Report showed that Resident 2 received four showers that month (the resident was care planned to receive eight showers a month).

Resident 7

Review of Resident 7's Face Sheet showed they admitted to the facility's memory care on [redacted]/2024.

Review of Resident 7's NSA, dated [redacted]/2024, showed the resident required staff assistance with showers two times a week.

Review of Resident 7's August 2024 electronic Resident Monthly Assignment Report showed that Resident 7 received four showers that month (the resident was care planned to receive eight showers a month).

<Resident 8>

Review of Resident 8's NSA, dated 07/26/2024, showed the resident required stand by assistance with one staff during ambulation (walking). Further review showed that Resident 8 was a high risk for falls due to cognitive impairment, history of multiple falls and required a motion sensor alarm for safety.

In an interview on 08/29/2024 at 2:02 PM, Staff F, Connections Care Coordinator, stated that Resident 2 had a fall outdoors on 08/06/2024. Staff F stated an ambulance

responded to evaluate and transport the resident to the hospital.

In an interview on 09/03/2024 at 1:28 PM, Staff M, Care Partner, stated that Resident 8 had a fall on 08/08/2024. Staff M stated they had left to provide care to another resident and when they returned to Resident 8, they saw the resident had fallen while trying to climb the fence outside. Staff M stated when the fall occurred on 08/08/2024, they had left the alarm off and the cottage door open, due to working alone as the only caregiver in the cottage, and the resident wanted to go outside. Staff M stated the resident should be able to go outside when they wanted to and not be kept inside due to only having one caregiver.

Review of the facility's staff schedule showed two unfilled shifts on 08/08/2024, the day of Resident 8's fall.

Review of an incident report, dated 08/08/2024, showed that staff observed Resident 8 had fallen in the outside courtyard after they had lost their balance. The report showed that Resident 8 was alone at the time of the fall.

Review of Resident 8's Hospital After Visit Summary, dated 08/08/2024, showed diagnoses of [redacted] and [redacted]

In an interview on 09/03/2024 at 1:28 PM, Staff E, Caregiver, stated when they work by themselves in a cottage they cannot do resident showers. Staff E further stated, "What choice do I have? I can't leave residents unattended, and we don't always a have a float to help."

Review of the Assisted Living Facility Resident Characteristic Roster showed that 30 residents resided in the memory care cottages. The Characteristic Roster showed the following:

-Cottage A had 11 memory care residents.

-Cottage B had nine residents. Two that needed a two person assist with transferring, one of which used a Hoyer lift. And an additional resident that needed to be assisted with eating.

-Cottage C had 10 residents. One resident that needed to be assisted with eating.

Review of the August 2024 staff schedule showed the documentation written onto the schedule of the days the facility memory care cottages were understaffed. Review of the "open" box on the schedule showed the following unfilled shifts (short staff):

Day unfilled shifts- 21 unfilled day shifts. No float staff scheduled for 10 of those shifts.
Evening unfilled shifts- 20 unfilled evening shifts. No float staff scheduled for 17 of those shifts.

In an interview on 08/29/2024 at 11:00 AM, Caregiver F, stated they had worked in a cottage by themselves on numerous occasions.

In an interview on 08/29/2024 at 11:42 AM, Caregiver E, stated they had worked in a cottage by themselves on numerous occasions.

In an interview on 08/30/2024 at 1:44 PM, Staff J, Executive Director, stated that the expectation was to always have two caregivers in each cottage.

Observation on 09/06/2024 at 2:00 PM, showed Staff F, Staff M, and Staff N, Caregivers, worked alone in each cottage. Observation showed that Staff F was assigned to Cottage B (which had two residents that were a two-person transfer).

In an interview on 09/06/2024 at 2:10 PM, Staff F stated they needed to have surgery and was unable to perform transfers. Staff F stated they had informed management about their inability to transfer residents. When the department inquired what Staff F did when residents needed transfer assistance, Staff F stated they would call the medication technician or a float staff to assist, which often resulting in delays as they would have to wait until staff were available.

This is a recurring deficiency previously cited on 12/05/2023 for subsection (1) (a).

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) 11/8/24 .

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

Administrator (or Representative) — Date: 10/16/24