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

07/15/2025

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) 62542 (Completion Date 07/15/2025) and 58579 (Completion Date 05/23/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/15/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(7) Not allow any staff person to abuse or neglect any resident.

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

The Department staff who did the On Site verification:
Sandra Fast, Community Complaint Investigator

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

Sincerely,

Stephanie Jenks, Community 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: 176608
Compliance Determination #: 58579
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sandra Fast
Investigation Date(s): 04/24/2025 through 05/23/2025
Complainant Contact Date(s): 04/24/2025, 05/06/2025

Allegation(s):
The identified resident had an unassessed and untreated wound.

Investigation Methods:

Sample:	Total residents: 76 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions
Interviews:	Administrative staff Nursing staff Residents
Record Reviews:	Medical records Facility policies Personnel files Staff training records

Investigation Summary:
Nursing staff did not follow their training to provide services. The facility failed to provide care that promoted health, dignity, respect, and resident rights. The facility failed to follow their protocol for resident's refusals of care. The identified resident suffered bodily harm and required an emergency room visit and home health care. Failed facility practice was identified related to Washington Administrative Code (WAC) 388-78a-2660 (1)(7) and cross-reference to Revised Code of Washington (RCW) 70.129.140 (1).

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

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 04/24/2025 of:

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

This document references the following complaint number(s): 176608

The following sample was selected for review during the unannounced on-site visit: 4 of 76 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sandra Fast, Community 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 — 06/04/2025 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) — 6/18/2025 Date

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(7) Not allow any staff person to abuse or neglect any resident.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide care in a manner which promoted health and well-being for 1 of 4 residents (Resident 1). This failed practice resulted in resident pain and discomfort and a lack of wound assessment and treatment of the resident's wounds, contributed to wound infection and the need for surgical interventions, and placed the resident at risk for health complications.

Findings included...

Review of the facility's policy titled, "PSL Wound Care," dated 10/2018, showed that the Health and Wellness Director (HWD), or their designee, would monitor resident wounds and contact the physician, home health/wound care specialist if a change in resident wound status occurred.

Review of the facility's undated policy titled, "Refusal of Assistance," showed that, if refusal of care had occurred, community associates should notify the executive director, wellness director or their designee and document the information in the resident service

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.

Administrator (or Representative) | Date

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(7) Not allow any staff person to abuse or neglect any resident.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide care in a manner which promoted health and well-being for 1 of 4 residents (Resident 1). This failed practice resulted in resident pain and discomfort and a lack of wound assessment and treatment of the resident's wounds, contributed to wound infection and the need for surgical interventions, and placed the resident at risk for health complications.

Findings included…

Review of the facility's policy titled, "PSL Wound Care," dated 10/2018, showed that the Health and Wellness Director (HWD), or their designee, would monitor resident wounds and contact the physician, home health/wound care specialist if a change in resident wound status occurred.

Review of the facility's undated policy titled, "Refusal of Assistance," showed that, if refusal of care had occurred, community associates should notify the executive director, wellness director or their designee and document the information in the resident service

notes.

Review of the facility's undated Characteristic Roster showed that the Resident 1 was admitted to the facility on [redacted]/2024.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 04/25/25, showed that Resident 1 was diagnosed with [redacted] and [redacted]. The NSA showed that Resident 1 required the assistance of one staff person for showers and to wash areas the resident could not reach, and that staff were to monitor the resident's skin on shower days. Further review of the resident's NSA showed that the resident had a history of refusing showers, not changing their incontinent brief when soiled, and for wearing soiled or odorous clothing. The NSA showed that staff were to monitor Resident 1's skin on shower days and as needed.

Review of Alert Charting for Resident 1, dated 03/04/2025 at 8:15 PM, showed that Staff B, Health and Wellness Specialist (HWS), was notified by Collateral Contact 1 (CC1), Agency Staff, that there was a wound on Resident 1's buttocks. Further review of the alert charting showed there was no documentation of any wound assessments performed by Staff B.

In an interview on 05/06/2025 at 3:18 PM, Staff F, Medication Technician (MT), stated that Resident 1 often refused to shower. Staff F stated that another MT had indicated to them that Resident 1 had wounds on their buttocks when they were admitted to the facility and that the resident was supposed to have home health. Staff F stated that if a resident had a pattern of refusing cares or showers, they were to notify the resident's family and the HWD.

In an interview on 05/12/2025 at 3:39 PM, Staff B, Health and Wellness Specialist, stated that they were not notified regarding the resident's refusals on a consistent basis.

Review of alert charting for Resident 1, dated 03/05/2025 at 7:59 PM, showed that the resident complained of soreness to their buttocks. Further review of the alert charting showed no nurse notification, wound observation or treatment was documented.

Review of alert charting for Resident 1, dated 03/06/2025 at 8:55 PM, showed that the resident complained of soreness to their buttocks. Further review of the alert charting showed no nurse notification, wound observation or treatment was documented.

Review of alert charting for Resident 1, dated 03/07/2025 at 1:19 PM. showed that the resident was asked how their bottom was, and that the resident stated, “I guess we will find out.” Further review of the alert charting showed no nurse notification, wound observation or treatment was documented.

Review of alert charting for Resident 1, dated 03/08/2025 at 12:45 PM, showed that the resident informed staff that their bottom was a little sore. Further review of the alert charting showed no nurse notification, wound observation or treatment was documented.

Review of Resident 1's alert charting showed that no wound observations or wound treatments were documented from 03/09/2025 thru 03/21/2025.

Review of alert charting for Resident 1, dated 04/24/2025 at 12:23 PM, showed that there was a wound on the resident’s buttocks. Further review showed no wound observation or treatment was documented.

Review of records from an outside Home Health Care Provider (HCP), dated 04/25/2025 at 11:45 AM, showed that the HCP assessed the resident. Further review showed that Resident 1 had a five cm area of induration (swelling), purulent discharge (thick, milky, or yellowish fluid that is a sign of infection), and malodor (unpleasant or offensive odor) on the right buttock with an initial diagnosis of [redacted]. Further review showed Resident 1 was transported to a local emergency room for treatment due to a need for analgesia (pain relief) beyond what the HCP was able to administer and for treatment of a wound infection.

Review of Resident 1’s alert charting, dated 04/25/2025 at 1:27 PM, showed that the resident was assessed by an Emergency Room (ER) Provider. Further review showed that Staff D, Medication Technician, was informed by the ER Physician that the resident's wound looked infected and that the wound, “looked like it was moving inwards [the wound edges had rolled inward caused by the wound healing process stopping].”

Observation on 04/24/2025 at 5:48 PM, showed Resident 1 was in their recliner with the footrest down. With permission, Resident 1’s buttocks were observed with a caregiver present. Observation showed Resident 1’s bilateral (both sides) buttocks had an eight centimeter (cm) by 10 cm purple discoloration on the medial aspect of their bilateral buttocks, that started at eight cm above their gluteal fold (the skin crease that forms below the buttocks) and extended down into and including their gluteal fold. Observation showed the purple discoloration was baseball shaped in size and was centered on Resident 1’s bilateral buttocks. Observation showed the caregiver applied gentle pressure to the discolored areas and there was minimal blanching (when the skin loses color from blood being pushed away from where pressure is applied which can indicate poor blood flow to the area causing tissues to break down and die).

Observation of the purple discoloration showed that there was a one and a half cm round open area within the discoloration. Closer observation showed there was purple colored adipose tissue (body fat and connective tissue) within the open area, and a yellow discoloration on the inside edge of the open area that was two millimeters (mm) in depth. Further observation showed a blistered area on the left buttock inside of the discolored area that measured two cm long and one cm wide. The blister was open at the top end and a one cm round open area was observed that contained purple colored adipose tissue within the wound. The open area measured one mm in depth. In an interview at that time, Resident 1 indicated the area was, “a little tender.”

Review of Resident 1’s ER visit records, dated 04/25/2025, showed that Resident 1 had an infected abscesses on both their left and right buttocks. Review of Resident 1’s lab report indicated that three types of bacteria were identified inside of the wound abscesses. The records showed a recommendation was made for antibiotics, wound care, and follow up by a general surgeon.

Review of Resident 1’s Primary Care Provider (PCP) visit notes, dated 4/30/2025, showed that the resident was diagnosed with [redacted] and [redacted]. The record showed that there was a hematoma (a collection of blood that pools outside of blood vessels) on Resident 1’s left buttock that had developed over time and was painful, and that it had led to an emergency room (ER) visit. Further review showed that the hematoma was cut open, drained and stitched closed at the ER. The records indicated that an outside home health agency was needed to monitor and treat the resident’s wounds.

In an interview on 05/07/2025 at 10:55 AM, Collateral Contact 2 (CC2), Resident Representative, stated that Resident 1 had buttocks wounds when they were admitted to the facility. CC2 stated that home health had not been involved in the resident’s wound care until recently. CC2 stated that Resident 1’s primary care provider had referred the resident to a plastic surgeon for assessment and treatment of the resident's wound.

In an interview on 05/08/2024 at 4:09 PM, Collateral Contact 3 (CC3), PCP, stated that Resident 1’s visit notes indicated that there was a wound noted on 02/25/2025. CC3 stated that another care provider at their office saw Resident 1 on 04/30/2025, and that a referral for wound care was made to a general surgeon. CC3 stated that Resident 1 had several risks related to having a surgery.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, North Point Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 7/1/2025

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

Administrator (or Representative) Date 6/18/2025

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff evaluated and took appropriate action for wounds sustained by 1 of 4 residents (Resident 1). These failures resulted in resident pain due to a lack of wound assessment and treatment, contributed to ongoing wounds with the need for surgical repair, and placed the resident at risk of ongoing skin breakdown.

Findings included...

Review of Resident 1's Negotiated Service Plan (NSP, the facility's titled negotiated service agreement), dated 04/25/2025, showed that the resident had a history of skin breakdown (wounds, damage to skin and underlying tissue) on their buttocks. The resident's NSP showed that staff were to monitor Resident 1's skin on shower days and to report any red, open, or other skin abnormalities to the nurse.

Review of the facility's undated Characteristic Roster showed that Resident 1 was admitted on [redacted]2024.

In an interview on 05/06/2025 at 3:18 PM, Staff F, Medication Technician (MT), stated that they were informed that Resident 1 had wounds on their buttocks when they were admitted to the facility and that the resident was supposed to have home health for

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-2120 Monitoring residents' well-being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff evaluated and took appropriate action for wounds sustained by 1 of 4 residents (Resident 1). These failures resulted in resident pain due to a lack of wound assessment and treatment, contributed to ongoing wounds with the need for surgical repair, and placed the resident at risk of ongoing skin breakdown.

Findings included…

Review of Resident 1’s Negotiated Service Plan (NSP, the facility’s titled negotiated service agreement), dated 04/25/2025, showed that the resident had a history of skin breakdown (wounds, damage to skin and underlying tissue) on their buttocks. The resident’s NSP showed that staff were to monitor Resident 1’s skin on shower days and to report any red, open, or other skin abnormalities to the nurse.

Review of the facility’s undated Characteristic Roster showed that Resident 1 was admitted on [redacted]/2024.

In an interview on 05/06/2025 at 3:18 PM, Staff F, Medication Technician (MT), stated that they were informed that Resident 1 had wounds on their buttocks when they were admitted to the facility and that the resident was supposed to have home health for

wound care.

Review of Resident 1's undated medical records showed that there was no facility setup or coordination of care with a home health agency for Resident's wounds.

Review of alert charting for Resident 1, dated 03/04/2025 at 8:15 PM, showed that Staff B, Health and Wellness Specialist, was notified by Collateral Contact 1 (CC1), Agency staff, that there was a wound on Resident 1's bottom. Further review of the alert charting showed there was no documentation of any wound assessments performed by Staff B.

Review of a faxed communication on 02/02/2025 at 4:04 PM from the facility to Resident 1's primary care provider (PCP), showed that the resident had excoriation (abrasion or scratches) and increased redness to their bilateral buttocks and that Resident 1 complained of pain and discomfort to the area when it was touched.

Review of alert charting for Resident 1, dated 03/04/2025 at 8:15 PM, showed that Staff B was notified by Collateral Contact 1 (CC1), Agency staff, that there was a wound on Resident 1's bottom. Further review of the alert charting showed there was no documentation of any wound assessments performed by Staff B.

Review of alert charting for Resident 1, dated 03/05/2025 at 7:59 PM, showed that the resident reported soreness to their buttocks. Further review of the alert charting showed no nurse notification, wound observation or treatment was documented.

Review of alert charting for Resident 1, dated 03/06/2025 at 8:55 PM, showed that Resident 1 stated their bottom was sore when asked if they were experiencing any pain. Further review of the alert charting showed no nurse notification, wound observation or treatment was documented.

Review of alert charting for Resident 1, dated 03/07/2025 at 1:19 PM showed no wound observation or treatment was documented.

Review of alert charting for Resident 1, dated 03/08/2025 at 12:45 PM, showed that the resident complained of soreness to their buttocks. Further review of the alert charting showed no nurse notification, wound observation or treatment was documented.

Review of alert charting for Resident 1, dated 03/09/2025 thru 03/21/2025 (12 days), showed no wound observation or treatment was documented.

Review of alert charting for Resident 1, dated 04/24/2025 at 12:23 PM, showed that

there was a wound on the resident's buttocks. Further review showed no wound observation or treatment was documented.

On 04/24/2025 at 5:48 PM, Resident 1's buttocks were observed with a caregiver present. Observation showed Resident 1's bilateral (both sides) buttocks had an eight centimeter (cm) by 10 cm purple discoloration. Observation showed the purple discoloration was baseball shaped in size and was centered on Resident 1's bilateral buttocks. Observation showed the caregiver applied gentle pressure to the discolored areas and there was minimal blanching (when the skin loses color from blood being pushed away from where pressure is applied which can indicate poor blood flow to the area causing tissues to break down and die). Observation of the purple discoloration showed that there was a one and a half cm round open area within the discoloration. Closer observation showed there was purple colored adipose tissue (body fat and connective tissue) within the open area, and a yellow discoloration on the inside edge of the open area. Further observation showed a blistered area on the left buttock inside of the discolored area that measured two cm long and one cm wide. The blister was open at the top end and a one cm round open area was observed that contained purple colored adipose tissue within the wound.

Review of records from an outside Home Health Care Provider (HCP), dated 04/25/2025 at 11:45 AM, showed that the HCP assessed the resident. Further review showed Resident 1 was transported to a local emergency room for treatment of a wound infection and pain control.

Review of Resident 1's alert charting, dated 04/25/2025 at 1:27 PM, showed that the resident was assessed by an Emergency Room (ER) Provider. Further review showed that Staff D, Medication Technician, was informed by the ER physician that the wound looked infected.

Review of Resident 1's primary care provider (PCP) visit notes dated 4/30/2025, showed that the resident had developed ulcerations (crater like open sores) on the right and left buttocks and had a hematoma on left buttock that had developed over time, was painful, and had led to an ER visit.

In an interview on 05/07/2025 at 10:55 AM, Collateral Contact 2 (CC2), Resident Representative, stated that Resident 1 had buttocks wounds when they were admitted to the facility. CC2 stated that home health wound care had not been initiated until recently. CC2 further stated the resident's wound required surgical assessment and treatment.

This is a recurring deficiency previously cited on 12/05/2023 and on 01/04/2023 for subsections (3) (4).

Statement of Deficiencies	License #: 2479	Compliance Determination #:58579
Plan of Correction	North Point Village, Assisted Living & Memory Care	Completion Date
Page 9 of 9	Licensee: PSL Associates, LLC	05/23/2025

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, North Point Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 7/7/2025

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

Administrator (or Representative) — Date: 6/18/2025

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