STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

08/16/2024

South Pointe Operations LLC
South Pointe Assisted Living
10330 4th Ave W
Everett, WA 98204

RE: South Pointe Assisted Living License # 2610

Dear Administrator:

This letter addresses Compliance Determination(s) 45722 (Completion Date 08/15/2024) and 38362 (Completion Date 06/18/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/15/2024 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-2500, WAC 388-78A-2510

The Department staff who did the on-site verification:
Jodi Condyles, ALF Licensor

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: South Pointe Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2610
Intake ID: 121232
Compliance Determination #: 38362
Region/Unit #: RCS Region 2 / Unit A
Investigator: Jodi Condyles
Investigation Date(s): 03/13/2024 through 06/18/2024
Complainant Contact Date(s): 03/06/2024, 04/22/2024, 06/18/2024

Allegation(s):

1. The Named Resident (NR) was left at a medical appointment unattended by the Assisted Living Facility (ALF) Named Staff (NS).
2. The ALF did not have a nurse for two weeks to provide care.
3. The NR had a wound on the left foot that was not reported to the NR's physician and the facility staff were not changing the NR's socks daily.
4. The NR's care needs were more than ALF staff could safely provide.
5. The ALF completed the bare minimum for repairs after broken pipes.
6. The NS falsified training certificates for trainings staff never completed.
7. The NS forged a signature on the NR rate sheet.

Investigation Methods:

Sample:
Total residents: 34
Resident sample size: 3
Closed records sample size: 0

Observations:
Identified resident
Residents
Activities
Dining
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Identified staff
Residents
Family members
Maintenance staff
Executive Director
Vice President of the ALF
Home Health Services
Pharmacy

Record Reviews:
Medical records
Hospital records

This document was prepared by Residential Care Services for the Locator website.

Incident investigation
Facility policies
Staff training records
NSA
Care Plans
Billing Contracts

Investigation Summary:

1. The NR was transported by the NS to a medical appointment on 2/28/2024. The NS stated that they updated the receptionist of the physician's office that they would be returning to pick up the NR after several other residents had been returned to the facility. The receptionist was aware of the arrangement and the NR was in the lobby waiting when the driver returned. The van driver completed the pick-up of the NR without incident. The NR's guardian stated that they had no concerns about the NR's appointment with the physician and the transportation there and back. No failed practice was found.
2. The Director of Nursing (DON) was working off site for two weeks in February due to illness but was available daily for facility needs. The DON's last day with the ALF was 3/10/2024. The ALF's Vice President (VP) stated that on 3/10/2024 the ALF formally hired a nurse delegation service and a Licensed Practical Nurse (LPN) to provide the clinical care needed by the residents. No failed practice was found.
3. Records reviewed showed the Power of Attorney (POA) was told of a callus on the NR's left great toe, including the description of the callus as closed, dry, intact with no concerns. The POA had a scheduled appointment for the NR to see the foot physician on 2/28/2024. The Executive Director (ED) stated during an interview on 3/27/2024, that the NR had an appointment with the foot physician scheduled by the NR POA due to the callus on the left great toe, but there was no open wound on the left foot prior to attending the appointment. The wound was discovered upon the NR's return to the facility at which time a call was placed to the NR's POA to discuss. No failed practice was found.
4. Record review showed caregivers received NR's specific training on 02/27/2024. On 3/27/2024 the ALF's ED confirm training had been completed and documentation was retained in each caregiver's employee file. No failed practice was found.
5. During an unannounced visit to the facility the areas of damage from the water pipes in December were observed. The ceiling tiles above the hair salon had fallen onto the floor, exposing the upper pipes and attic space and damaging the floor. During an interview with the AFL's Vice President (VP) stated that the ALF had several bids out to have the repair completed and is working through the process with construction review to meet all requirements of the state for safe repair of the impacted areas. The water damage was also addressed in a facility self-report. No failed practice was found.
6. Record review showed no falsification of records. The ALF's staff training for Dementia and Mental Health showed 2 of 3 staff members did not complete specialty training within 120 days of hire. On 6/10/2024 the ALF's VP confirmed training had not been completed. Failed practice was found. A citation was issued for Washington State Administrative Code 388-78A-2500 and 388-78A-2510.
7. Record review showed the NR's significant other signed the facilities document Move in Fees and Rate Sheet. On 6/3/2024, the NR's significant other stated that they had signed the initial paperwork including the cost sheet. No failed practice was found.

Conclusion / Action:

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

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3906-172nd St NE, Suite #100, Arlington, WA 98223

Statement of Deficiencies	License #: 2610	Compliance Determination # 38362
Plan of Correction	South Pointe Assisted Living	Completion Date
Page 1 of 4	Licensee: South Pointe Operations LLC	06/18/2024

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 03/13/2024 and 06/03/2024 of:

South Pointe Assisted Living
10330 4th Ave W
Everett, WA 98204

This document references the following complaint number(s): 121232, 121299, 121296, 121250

The following sample was selected for review during the unannounced on-site visit: 3 of 34 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Jodi Condyles, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Kim Ripley
Residential Care Services

6/25/2024
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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Administrator (or Representative)

7.10.24
Date

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 3 staff (Staff D and E) completed specialized mental health training. This failure resulted in Staff D and Staff E not being trained to provide care to residents with a mental health diagnoses and placed all residents with a diagnosis of mental health at risk of not receiving proper care.

Findings included...

The ALF's Resident Characteristic Roster dated 3/17/2024, showed 1resident living in the ALF had a [redacted] diagnosis.

Review of the ALF's employee files showed:

Staff D, Caregiver/Medication Technician, was hired on 11/02/2023. There was no documentation of specialized mental health training.

Staff E, Caregiver, was hired on 02/05/2023. There was no documentation of specialized mental health training.

On 03/27/2024 at 12:15 PM, Staff A, Executive Director, stated that they provide specialty training for new staff once a month and maintain a copy of the certificate of completion in the employees' files for review.

On 06/07/2024 at 4:20 PM, Staff B, Vice President, stated that Staff D and Staff E did not complete the specialized mental health taught by Staff A.

Plan/Attestation Statement

This document was prepared by Residential Care Services for the Locator website.

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, South Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 8/2/24 .

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

Administrator (or Representative) — Date: 7.10.24

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 3 staff (Staff D and E) completed specialized dementia training. This failure resulted in Staff A and Staff B not being trained to provide care to residents with dementia and placed all residents with a diagnosis of dementia at risk of not receiving proper care.

Findings included...

The ALF's Resident Characteristic Roster dated 3/17/2024, showed 8 residents living in the ALF had a [redacted] diagnosis.

Review of the ALF's employee files showed:

Staff D, Caregiver/Medication Technician, was hired on 11/02/2023. There was no documentation of specialized dementia training

Staff E, Caregiver, was hired on 02/05/2023. There was no documentation of specialized dementia training.

On 03/27/2024 at 12:15 PM, Staff A, Executive Director, stated that they provide specialty training for new staff and maintain a copy of the certificate of completion in the employees' files for review.

On 06/07/2024 at 4:20 PM, Staff B, Vice President, stated that Staff D and Staff E did not

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complete the dementia specialty training.

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, South Pointe Assisted Living is or will be in compliance with this law and / or regulation on (Date) 8.2.24.

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

Administrator (or Representative) — Date: 7.10.24

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