



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

06/24/2024

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) 42701 (Completion Date 06/13/2024) and 34965 (Completion Date 03/20/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/13/2024 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-2210-1-b, WAC 388-78A-2640-1-a

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,

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



Residential Care Services Investigation Summary Report

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

License/Cert.#: 2610

Intake ID: 113398

Compliance Determination #: 34965

Region/Unit #: RCS Region 2 / Unit A

Investigator: Jodi Condyles

Investigation Date(s): 01/09/2024 through 03/20/2024

Complainant Contact Date(s): 01/08/2024, 03/27/2024

Allegation(s):

- 1.The named resident (NR) was given a medication even though the physician had discontinued the medication.
 - 2.The NR had a fall during a transfer hitting the left side of the head causing an injury and the POA wasn't notified of the injury sustained.
 - 3.The facility didn't have a full time nurse and was leaving medical/nursing related decision for the executive director who was not licensed and didn't have the training to make these types of decisions.
 - 4.The facility did not provide the required N-95 masks during a COVID outbreak at the facility.
-

Investigation Methods:

Sample:	Total residents: 34 Resident sample size: 4 Closed records sample size: 0
Observations:	Medication administration Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Family members Executive Director
Record Reviews:	Medical records Hospital records Facility policies Staff patterns Incident investigation Staff patterns

Investigation Summary:

1. Records showed the NR returned from the hospital with a new medication order. The new order was not followed. Failed practice was identified. A citation was issued for noncompliance of WAC 388-078A-2210 (1) (b) Medications services.

2. Interview and record review showed the NR slipped during a transfer from a recliner to a wheelchair, falling forward and hitting the left upper forehead. The NR was placed back in the recliner and assessed for the wound above the left eyebrow. The facility called 911 to have the NR transported to the local hospital for an additional assessment and care. The NR refused treatment and a transport to the hospital. The facility offered to contact the NR's Power of Attorney (POA) to discuss transport to the hospital, the NR refused and didn't want the POA contacted. The facility completed an investigation and ruled out abuse and neglect. The NR was placed on alert charting to monitor for any status change. The ED and RN were notified of the fall but the POA was not contacted. Failed practice was identified. A citation was issued for noncompliance of WAC 388-78A-2640 1(a) Reporting significant change in a resident's condition.

3. Director of Nursing was an open position from 11/10/2023 through 01/01/2024, until the position was filled on 01/02/2024. The nurse delegator was available to the facility for clinical support while the ALF had no Director of Nursing. No failed Practice.

4. The Assisted Living Facility (ALF) identified eight residents and eight staff that tested positive for COVID-19. The ALF made the required notifications, including calls to the Department Hotline, the local health jurisdiction and all staff and resident representatives. The ALF followed the infection control and testing guidance provided by the local health jurisdiction. The ALF closely screened all residents and staff for signs/symptoms consistent with COVID-19 and provided the necessary PPE. Staff were fit tested and the mask were observed and reported to be available. No Failed Practice.

Conclusion / Action:

- 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 #: 2610	Compliance Determination # 34965
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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 01/09/2024 and 03/13/2024 of:

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

This document references the following complaint number(s): 113398

The following sample was selected for review during the unannounced on-site visit: 4 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

04/01/2024

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.

M. Y. Kaula

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Administrator (or Representative)

Date

WAC 388-78A-2210 Medication services.

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 4 residents (Resident 1) received a medication as prescribed by a physician. This failure resulted in Resident 1 receiving one dose of a discontinued medication and placed Resident 1 at risk for medical complications and not having their medication needs met.

Findings included...

Review of the ALF's policy titled, "Medication/Treatment Management", showed it was the responsibility of the administrator to maintain adequate professional oversight of the medications and treatment administration system.

Review of the ALF's Disclosure of Services showed that the facility would have licensed staff available to administer medications directly or supervise the administration of medications by unlicensed staff.

Resident 1

Resident 1 was admitted on [REDACTED]/2023 with multiple medical diagnoses including [REDACTED] and [REDACTED]

Review of the Negotiated Service Plan dated and signed on 10/04/2023 showed Resident 1 would have all medications ordered, stored, and administered by the ALF.

Review of Resident 1's hospital discharge orders dated [REDACTED]/2023 at 3:50 PM, showed Warfarin (a blood thinning medication) 5mg was discontinued. The Warfarin order was reviewed by the hospital physician at 3:22 PM and signed at 3:46 PM. The discharge orders

Moycauld

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were sent to the facility by the hospital social worker at 3:50 PM. Confirmation the fax was received by the facility was noted on page 1, written in pen, received with the initials MG/ED and dated [REDACTED]/2023.

Review of the Re-Admission Screening Tool/Short Stay Assessment dated [REDACTED]/2023 showed Staff A, Executive Director, completed the assessment, reviewed the discontinued Warfarin order, and sent the order to the pharmacy and Resident 1's physician for review.

Review of Residents 1's Electronic Medication Administration Record (EMAR) dated [REDACTED]/2023 at 6:26 PM, showed Warfarin 5mg was given by Staff D, Medication Technician (Med Tech).

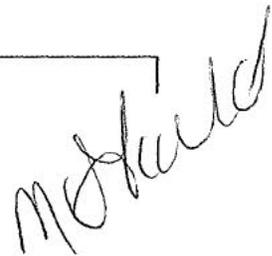
In an interview on 01/18/2024 at 3:44 PM, Staff A stated that the nurse was out of the building and unavailable when Resident 1 returned to the facility. There wasn't a nurse hired until [REDACTED]/2024, 7 days after the resident returned from the hospital. Staff A received the discharge orders from the hospital, reviewed and sent the orders to the pharmacy and Resident 1's primary care physician circling the discontinued Warfarin to draw attention to the change made. The EMAR was not updated with the discontinuation order for the Warfarin and the medication was given as the EMAR directed on [REDACTED]/2023 at 6:26 PM by Staff D.

In an interview on 01/26/2024 at 2:52 PM, Staff B, Director of Nursing, stated that the facility did not have a nurse available to review the hospital discharge orders dated [REDACTED]/2023 when Resident 1 arrived back at the facility. Staff B stated that given the hospital orders were signed by a physician, the Warfarin should had been discontinued upon arrival back at the facility.

In an interview on 03/15/2024 at 8:38 AM, Collateral Contact 2 (CC2), Matrix Pharmacy Manager, stated that they received the discontinuation order for Warfarin on [REDACTED]/2023 from Staff A. CC2 stated that the pharmacy does not update the ALF's EMAR, the clinical staff at the ALF reviews physician orders and updates the EMAR.

In an interview on 03/20/2024 at 11:13 AM, Collateral Contact 1 (CC1), stated that they met with Staff A on 01/02/2024 to discuss the outcome of Resident 1's fall on 12/24/2023. CC1 stated that Staff A explained when they received the orders for the discontinuation of Warfarin, they didn't have a licensed nurse in the building at the time so forwarded the orders to the pharmacy and Resident 1's physician but did not update the EMAR.

Plan/Attestation Statement



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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) ~~5/7/24~~ 4-28-24

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

M. Gould

 Administrator (or Representative)

A 4/3/24

 Date

*OK per email to Cheryl
 Date Mm 4-9-24*

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the Power of Attorney (POA) when 1 of 4 residents (Resident 1) had a change in status due to a fall. This failure resulted in Resident 1's POA not being notified of a fall, delayed medical treatment for Resident 1 and placed all residents at risk for complications related to delay in notification of resident representatives.

Findings included...

Review of the ALF's policy titled, "Resident Falls", showed that the Medication Technician (Med Tec.) immediately after a resident fall, will contact the resident's POA by phone, and to continue to call until the POA is reached. Leaving a voicemail is not an acceptable form of communication when it comes to an incident with a resident.

Review of ALF's policy titled, " Incident/Accident Report", showed that the Medication Technician (Med Tec.) on shift is responsible for contacting the POA/family after an incident with a resident.

Review of an employee notice posted by Staff A, Executive Director, dated 11/30/2023 showed facility instructions stated that after an incident to notify the POA/family of the event.

Review of the Resident 1's Face Sheet, showed Resident 1 was admitted on [redacted] /2023 with multiple medical diagnoses including [redacted]

M. Gould

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<u>M. Gauld</u>	<u>4/3/24</u>
Administrator (or Representative)	Date

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M. Gauld