STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

BALLARD LANDMARK INN LLC
BALLARD LANDMARK
5433 LEARY AVENUE NW
SEATTLE, WA 98107

RE: BALLARD LANDMARK License # 2055

Dear Administrator:

This letter addresses Compliance Determination(s) 33301 (Completion Date 12/07/2023) and 30159 (Completion Date 10/09/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/07/2023 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-2090-6-e, WAC 388-78A-2700-1-g-i, WAC 388-78A-2700-1-g-iv, WAC 388-78A-2700-1-g-vi, WAC 388-78A-2690-1, WAC 388-78A-2690-6-c, WAC 388-78A-2690-7-a, WAC 388-78A-2690-7-b, WAC 388-78A-2690-7, WAC 388-78A-2690-9, WAC 388-78A-2660-1, WAC 388-78A-2070-1, WAC 388-78A-2480-1, WAC 388-78A-2480-2, WAC 388-78A-2480, WAC 388-78A-24642-1, WAC 388-78A-2474-1, WAC 388-78A-2474-2-c, WAC 388-78A-2140-1-a, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-2, WAC 388-78A-2140-2-a, WAC 388-78A-2140-2-b, WAC 388-78A-2100-1, WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b

The Department staff who did the on-site verification:
Erin Steinbrenner, Nursing Consultant Institutional
Faith Le, NCI

If you have any questions, please contact me at (425)670-6070.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

10/19/2023

Licensee: BALLARD LANDMARK INN LLC
BALLARD LANDMARK
5433 LEARY AVENUE NW
SEATTLE, WA 98107

RE: BALLARD LANDMARK License # 2055

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 10/09/2023 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report,
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

10/10/2023

Licensee: BALLARD LANDMARK INN LLC
BALLARD LANDMARK
5433 LEARY AVENUE NW
SEATTLE, WA 98107

RE: BALLARD LANDMARK License # 2055

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 10/09/2023 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

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- Begin the process of correcting the deficiency or deficiencies immediately;
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  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Jamie Singer, Field Manager
Residential Care Services
Region 2, Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

- Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
- Have your plan approved by the Department.

You May:

- Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

In Addition, You May:

- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  - What specific deficiency or deficiencies you disagree with;
  - Why you disagree with each deficiency; and
  - Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - Send your request to.

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (425)670-6070.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Enclosure

Jamie Singer, Field Manager
Residential Care Services
Region 2, Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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  o Send your request to:

IDR Program Manager
Department of Social and Health Services
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Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

• Please contact me at (425)670-6070.

Sincerely,

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 the unannounced on-site full inspection and complaint investigation on 09/27/2023 and 09/29/2023 of:
BALLARD LANDMARK
5433 LEARY AVENUE NW
SEATTLE, WA 98107

This document references the following complaint numbers: 100216.

The following sample was selected for review during the unannounced on-site visit: 9 of 47 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Faith Le, NCI
Erin Steinbrenner, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

10/10/2023
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)

10/10/2023
Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to ensure a system was in place to complete an Assessment for 3 of 3 sampled residents (Residents 1, 5 and 6) that included their ability to safely use and the risks and benefits of side rails. Additionally, the ALF also failed to perform a full assessment within 14 days, after move-in for 1 of 2 sampled residents (Resident 7). These failures placed Residents 1, 5, 6, and 7 at risk of injury and unmet care needs.

Findings included...

NOTE: On 05/15/2013 a "Dear Assisted Living Facility Administrator" letter was issued to ALF providers related to the safety risks associated with the use of all medical devices, including transfer poles, Posey or lap belts, and side bed rails. The letter stated, "Potential risks of medical devices may include strangling, suffocating, bodily injury, skin bruising, cuts, scrapes, agitation, feeling isolated or unnecessarily restricted."

Resident 1

Review of a Face Sheet showed the ALF admitted Resident 1 on [redacted]/2023 with multiple diagnoses.

Observation and interview, on 09/29/2023 at 11:29 AM, showed two rectangular metal bed rails secured to the right and left sides of Resident 1's hospital bed, measured to be 32 inches in length and 18 inches in height from the top bar to the lower bar. Observation showed 8 vertical bars located between the frame with 4-inch gaps between each vertical bar. Resident 1 stated the bed rail was added after she fell out of bed.

Review of an Assessment, dated 05/31/2023, showed Resident 1 required assistance of two staff for mobility and transfers and showed no mention of side rails. Review showed the Resident had not been assessed of her ability to safely use side rails. There was no documentation to show Resident 1 was aware of the risks and benefits of side rail use.

In interview, on 09/29/2023 at 1:30 PM, Staff G (Wellness Director) stated she was not aware of side rails on Resident 1's bed and would do a walk-through of all the rooms to look for bed rails. Staff G confirmed the device had not been assessed by the facility, it was not on Resident 1's Assessment.

Resident 5

Record review of a Face Sheet, dated 09/27/2023, showed the facility admitted Resident 5 on [redacted]/2022 with diagnoses including [redacted].

An observation and interview, on 09/29/2023 at 9:55 AM, with Resident 5 in his apartment showed a half bed rail on the right side of the bed. Resident 5 stated, "I use the side rail to help me with transfers and to roll over in bed."

Record review of Resident 5's Assessment, dated 05/30/2023, showed the Resident had not been assessed of his ability to safely use side rails. There was no documentation to show Resident 5 was aware of the risks and benefits of side rail use.

In an interview, on 09/29/2023 at 11:15 AM, Staff G (Wellness Director) stated that the facility was not aware there was a bed rail on Resident 5's bed. Staff G confirmed the device had not been assessed by the facility, it was not on Resident 5's Assessment.

Resident 6

Record review of a Face Sheet, dated 09/27/2023, showed the facility admitted the Resident 6 on [redacted]/2020 with diagnoses including [redacted]

and [redacted].

An observation and interview, on 09/29/2023 at 10:35 AM, with Resident 6 in her

apartment showed bed rails on the bed. Resident 6 stated, "I use the siderails to help me not fall out of bed."

Record review of Resident 6's Assessment, dated 10/19/2022, showed the Resident had not been assessed of her ability to safely use side rails. There was no documentation to show Resident 6 was aware of the risks and benefits of side rail use.

In an interview, on 09/29/2023 at 11:20 AM, Staff G stated that the facility was not aware there was a bed rail on Resident 6's bed. Staff G confirmed the device had not been assessed by the facility, it was not on Resident 6's Assessment.

Resident 7

Record review of a Face Sheet showed the ALF admitted the Resident 7 on [redacted]/2023. Review of Resident 7's records showed the most recent Assessment was performed on 8/2023 as the "Pre-Admission Assessment." No updated assessment was found within 14 days of Resident 7's admission.

In an interview, on 09/28/2023 at 2:00 PM, Staff G stated that she used Resident 7's Pre-Admission Assessment as an Annual Assessment. Staff G confirmed an updated Assessment was not done after Resident 7 was admitted into the facility.

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, BALLARD LANDMARK is or will be in compliance with this law and / or regulation on (Date) 11/23/23.

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

Administrator (or Representative) — Date 10/10/23

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

(i) On-duty staff persons' responsibilities;

(iv) Alternative resident accommodations;

(vi) Emergency communication plan.

This requirement was not met as evidenced by:

Based on interview and record review, the Assiste dLiving Facility (ALF) failed to develop and maintain an emergency preparedness plan to assist the ALF in anticipating and addressing needs for natural and man-made disasters. This failure placed 47 residents and staff in at risk of danger and displacement in the event of emergency or disaster.

Findings included...

Record review of the ALF's Emergency Preparedness Manual binder, showed on-duty staff person's responsibilities were not identified. Location of utility shutoffs for gas, water, electric, and generator were not accurately identified. Alternative accommodation for residents was not identified.

In an interview, on 09/28/2023 at 2:35 PM, Staff A (Executive Director) acknowledged the ALF's Emergency Preparedness Manual binder was not complete or specific to the layout of facility.

In an interview, on 09/29/2023 at 1:20 PM, Staff K (Concierge) stated they could not find information on the responsibilities of the ALF's on-duty staff person in the case of an emergency, where residents would temporarily relocate if they were displaced from the ALF, or identify the location where staff and residents were to meet if there was an evacuation.

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, BALLARD LANDMARK is or will be in compliance with this law and / or regulation on (Date) 11/23/23.

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

Administrator (or Representative) — Date: 10/10/23

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(1) Audio or video monitoring equipment may not be installed in the assisted living facility

to monitor any resident apartment or sleeping area unless the resident or the residents' representative has requested and consents to the monitoring.

(6) If the resident requests the assisted living facility to conduct audio or video monitoring of his or her apartment or sleeping area, before any electronic monitoring occurs, the assisted living facility must ensure:

(c) The resident and the assisted living facility have agreed upon a specific duration for the electronic monitoring and the agreement is documented in writing.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

(9) For the purpose of consenting to video electronic monitoring without an audio component, the term "resident" includes the resident's representative.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure an evaluation, agreed upon duration, or signed consent was completed for 1 of 1 resident (Resident 7) who had a video camera in her apartment. This placed Resident 7 at risk of violation of privacy.

Findings included...

Record review of Charting Notes, dated 09/21/2023, showed Resident 7 has a "Ring camera" inside her apartment. Review of Resident 7's records did not show documentation evaluating the need for, the duration of, or consent of electronic monitoring.

In an interview, on 09/27/2023 at 2:50 PM, Staff G (Wellness Director) confirmed Resident 7 had an electronic camera inside her apartment, and the ALF did not have an evaluation and signed consent for electronic monitoring.

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, BALLARD LANDMARK is or will be in compliance with this law and / or regulation on (Date) 11/23/23.

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

Administrator (or Representative) — Date: 10/10/23

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

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to protect the confidentiality and privacy of 3 of 3 former residents (Residents 1, 2, and 5) by displaying a confidential list of resident names in a public location. This resulted in a violation of former Residents 1, 2 and 5's privacy.

Findings included...

Observation, on 09/27/2023 at 11:13 AM, during the environmental tour with Staff A (Executive Director) and Staff I (Maintenance Director), the Department's Representative observed a binder located near the front desk, to include prior licensing inspection reports.

Review of the binder showed a Statement of Deficiencies (SODs), dated 11/08/2021, with a confidential list of resident's names (a key to the residents listed in the SOD). Review of the SOD with the attached resident list, showed Residents 1, 2 and 5's medical conditions and other personal information. On the top of the list of resident's names was printed, "CONFIDENTIAL, Do Not Post This List In The Facility."

In an interview, on 09/27/2023 at 11:13 AM, Staff A stated the resident list should not be in the binder and removed it.

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, BALLARD LANDMARK is or will be in compliance with this law and / or regulation on (Date) 11/23/23.

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

Administrator (or Representative) — Date: 10/10/23

WAC 388-78A-2070 Timing of preadmission assessment.

(1) Unless there is an emergency, the assisted living facility must complete the preadmission assessment of the prospective resident before each prospective resident moves into the assisted living facility.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete a Pre-Admission Assessment for 3 of 9 sampled residents (Residents 1, 2 and 9). This placed Residents 1, 2 and 9 at risk for not receiving a level of care appropriate for their needs.

Findings included...

Review of a Resident Characteristic Roster (RCR) showed the ALF admitted Resident 1 on [redacted]/2023. Review of records showed an Assessment was conducted for Resident 1 on the day after they moved-in, on [redacted]2023. The records did not show the facility admitted Resident 1 on an emergent basis.

Review of a RCR showed the ALF admitted Resident 2 on [redacted]/2023. Review of records showed an Assessment was conducted for Resident 2 on their date of move in, [redacted]/2023. The records did not show the facility admitted Resident 2 on an emergent basis.

Review of a RCR showed the ALF admitted Resident 9 on [redacted]/2023. Review of records showed an Assessment was conducted for Resident 9 on their date of move in, [redacted]/2023. The records did not show the facility admitted Resident 9 on an emergent basis.

During an interview, on 09/27/2023 at 2:10 PM, Staff G (Wellness Director) stated she would finish, date and sign the Preadmission Assessment on the day the resident moved into the ALF. Staff G confirmed the dates of Residents 1, 2 and 9 Preadmission Assessments showed they were completed the day of or the day after they moved in.

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, BALLARD LANDMARK is or will be in compliance with this law and / or regulation on (Date) 11/23/23.

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

Administrator (or Representative) 10/10/23 Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489 , "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on record review and interview, the Assisted Living Facility (ALF) failed to ensure 2 of 6 sample staff (Staff A and Staff E) were screened for tuberculosis (TB) within three days of employment. This failure placed all 47 residents living in the ALF at risk of exposure to TB.

Findings included...

Record review of a Staff List, dated 09/27/2023, showed Staff A was hired on 09/04/2012 and became Executive Director on 05/23/2023. Review of Staff A's records showed no documentation of TB screening.

Record review of a Staff List, dated 09/27/2023, showed Staff E (Certified Nurse Assistant) was hired on 09/09/2017. Review of Staff E's records showed no documentation of TB screening.

In an interview, on 09/28/2023 at 2:16 PM, Staff H (Assistant Executive Administrator) confirmed he was unable to locate TB records for Staff A or Staff E.

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, BALLARD LANDMARK is or will be in compliance with this law and / or regulation on (Date) 11/23/23.

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

Administrator (or Representative) — Date: 10/10/23

WAC 388-78A-24642 Background checks National fingerprint background check.

(1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure a national fingerprint background check (NFBC) for 2 of 6 sampled staff (Staff E and F) was completed. This placed 47 residents at risk for receiving care from staff whose criminal background history was unknown.

Findings included...

Review of records for Staff E (Certified Nurse Assistant), hired on 09/19/2017, and Staff F (Certified Nurse Assistant), hired on 01/15/2018, did not show Staff E or F completed a NFBC.

In an interview, on 09/29/2023 at 8:30 AM, Staff H (Assistant Executive Administrator) confirmed Staff E and Staff F did not have completed NFBC.

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, BALLARD LANDMARK is or will be in compliance with this law and / or regulation on (Date) 11/23/23.

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

Administrator (or Representative) — Date: 10/10/23

WAC 388-78A-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 6 sampled staff (Staff A, B and D) had the necessary specialized training to fulfill their expected responsibilities. This failure placed 47 residents at risk of harm from untrained care staff.

Findings included...

NOTE: 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.

NOTE: 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).

Review of a Resident Characteristic Roster, showed the ALF provided care and services to 47 residents of which 5 had a diagnosis of [redacted] and 6 had a [redacted] diagnosis.

Review of staff records showed the ALF hired Staff A (Executive Director) on 05/23/2023. Review of staff records on 09/28/2023 showed Staff A did not have the required specialized dementia and mental health training.

Review of staff records showed the ALF hired Staff B (Certified Nurse Assistant) on 03/27/2023. Review of staff records on 09/28/2023 showed Staff B did not have the

required specialized dementia and mental health training

Review of staff records showed the ALF hired Staff D (Certified Nurse Assistant) on 10/24/2022. Review of staff records on 09/28/2023 showed Staff D did not have the required specialized dementia and mental health training.

In interview, on 09/28/2023 at 2:21 PM, with Staff A (Executive Director) and Staff H (Assistant Executive Director) both confirmed Staff A, B and D, had not completed Dementia and Mental Health specialty training. Staff A stated the training is taught by a corporate nurse and would get this scheduled.

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, BALLARD LANDMARK is or will be in compliance with this law and / or regulation on (Date) 11/23/23

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

Administrator (or Representative) — Date: 10/10/23

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident

in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to identify and document in the Negotiated Service Agreement (NSA) clearly defined roles and responsibilities of family medication assistance and a private caregiver in 2 of 3 sampled residents (Resident 2 and 6) or safety plan interventions for 1 of 3 sampled residents (Resident 5). These failures placed Residents 2, 5, and 6 at risk for not receiving necessary care and services.

Findings included...

Resident 2

Review of a Face Sheet showed the ALF admitted Resident 2 on [redacted]/2023. Review of an Assessment, dated 06/07/2023, under the category of Medication Assistance Level Required, showed family ordered and administered medications with a secondary family member listed as a backup plan.
In interview and observation, on 09/29/2023 at 10:45 AM, Collateral Contact 1 (Resident 2's spouse) confirmed medications were managed by family. Observation showed medications were stored in Resident 2's apartment.

Review of a Care Plan (CP- equivalent to an NSA), dated 08/24/2023, showed the facility provided medication management and did not correctly identify Resident 2's family was providing medication assistance. Review of the CP showed it did not include an alternate plan should family not be able to provide medication management to Resident 2.

In an interview, on 09/28/2023 at 2:52 PM, Staff G (Wellness Director) agreed Resident 2's CP did not accurately reflect who was managing Resident 2's medications or include an alternate plan.

Resident 5

Record review of a Face Sheet, dated 09/27/2023, showed the facility admitted Resident 5

on [redacted]/2022 with diagnoses including [redacted].

In an interview, on 09/29/2023 at 10:00 AM, Resident 5 reported the ALF staff regularly refused to transfer him onto a bedside commode for bowel movements.

In an interview, on 09/29/2023 at 11:15 AM, Staff G stated Resident 5 occasionally used marijuana which caused his coordination to be impaired. Staff G stated that when Resident 5 was under the influence of marijuana the ALF care staff would not transfer the resident to the commode due to the risk of falling. Staff G stated during those occasions, the ALF staff would assist Resident 5 in having a bowel movement in his incontinence brief. Staff G stated that Resident 5 had agreed to the safety plan.

Review of a CP, dated 05/30/2023, showed no information about Resident 5's use of marijuana, its effect on Resident 5's coordination, or the safety plan and change in toileting interventions when under the influenced of marijuana.

Resident 6

Record review of Resident 6's Face Sheet, dated 09/27/2023 showed the facility admitted the Resident on [redacted]/2020 with multiple disabling diagnoses.
An observation and interview, on 09/29/2023 at 10:35 AM, showed Resident 6 had a private caregiver (PCG) in her apartment. Resident 6 stated the PCG worked and assisted her with all her care daily from 8:30 AM to 4:30 PM. Resident 6 stated when her PCG was present, the ALF staff did not assist in any care.

Review of Resident 6's CP, dated 10/19/2022, showed Resident 6 had a PCG but there was no mention of the PCG's schedule. There was no alternative plan regarding who would care for Resident 6 if the PCG was unable to be at the ALF or perform the necessary duties to assist the resident.

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, BALLARD LANDMARK is or will be in compliance with this law and / or regulation on (Date) 11/23/23.

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

Administrator (or Representative) 10/10/23 Date

WAC 388-78A-2100 On-going assessments. The assisted living facility must:

(1) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(2) Complete an assessment specifically focused on a resident's identified problems and related issues:

(a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to complete an ongoing assessment for a new skin issue for 1 of 9 sampled residents (Resident 2) and failed to update 1 of 9 sampled resident's (Resident 8) annual assessment. This placed Resident 2 at risk for worsening skin breakdown and related health issues and Resident 8 at risk for unmet health needs.

Findings included...

Resident 2

Review of a Face Sheet showed the ALF admitted Resident 2 on [redacted]/2023 with multiple diagnoses.

Review of a Progress Note, dated 09/06/2023, showed Resident 2 had informed a licensed nurse of a boil on their right heel and home health had ordered a medical boot.

In interview, on 09/29/2023 at 10:45 AM, Resident 2 and their spouse (Collateral Contact 1) confirmed the wound to Resident 2's right heel developed over a month ago. Resident 2 stated they had severe peripheral neuropathy (damage to the nerves) and as a result, had minimal sensation to their lower extremities. Resident 2 stated Home Health ordered protective foam booties and a foam wedge to be placed under both feet when in bed.

Review of Resident 2's assessment, dated 06/08/2023, showed no mention of skin breakdown in the Skin Issues assessment category and showed only weekly skin checks to be completed for Nursing Services.

In interview, on 09/28/2023 at 3:00 PM, Staff G (Wellness Director) confirmed Resident 2 had a wound on their right heel and the staff had been instructed to elevate the resident's feet when in bed with a foam wedge. Staff G stated the wound and pressure relief information had not been added to Resident 2's Assessment.

Resident 8

Record review showed Resident 8's Assessment, dated 09/22/2022, had not been updated at least annually.

In interview, on 09/28/2023 at 2:05 PM, Staff G confirmed Resident 8's annual assessment has not been completed.

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, BALLARD LANDMARK is or will be in compliance with this law and / or regulation on (Date) 11/23/23.

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

Administrator (or Representative) — Date: 10/10/23