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) 25623 (Completion Date 06/22/2023) and 21896 (Completion Date 04/24/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/22/2023 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-2210-1-b, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Cathy Prentice, Complaint Investigator

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

Residential Care Services
Investigation Summary Report

Provider/Facility: BALLARD LANDMARK
Provider Type: Assisted Living Facility
License/Cert.#: 2055
Compliance Determination #: 21896
Intake ID: 74639
Investigator: Cathy Prentice
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 03/30/2023 through 04/24/2023
Complainant Contact Date(s): 03/29/2023, 04/25/2023

Allegation(s):

1. The Named Resident (NR) was hospitalized following a fall with high blood sugar, bad restless leg syndrome, dizziness, and altered mental status.
2. The Named Resident (NR) was given another residents medication.
3. The NR could not have an MRI due to heavy sedation.
4. The NR's son requested on several occasions for the NR to be re-assessed to self medication management.
5. The NR's family was not told by the ALF of the medication error.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 4 Closed records sample size: 1
Observations:	Delivery of care and services; staff interactions with residents; residents' appearance; environment.
Interviews:	Named resident, legal representative, other residents, staff, administration
Record Reviews:	Resident care records, assessment, service agreement, investigations, facility policies, other pertinent records

Investigation Summary:

1. Record review, interview and observation showed the ALF did not have a safe medication delivery system that resulted in a medication error. Record review and interview showed this resulted in the NR falling and going to the hospital. Failed practice identified see WAC 388-78A-2210.
2. Record review, interview and observation showed the ALF did not have a safe medication delivery system that resulted in a medication error. Failed practice identified see WAC 388-78A-2210.
3. Record review showed the medication error included a sedating medication, the ER record indicated the NR was given another sedating medication. The NR was also in the ER overnight that could cause sleep deprivation. Record review, interview and observation showed the ALF did not have a safe medication delivery system that resulted in a medication error. Failed practice identified see WAC 388-78A-2210.
4. In interview, the Director of Nursing (DNS) stated the NR's family had never

requested a re-assessment for self-medication management and was following notes from the NR's speech therapy. The DNS, a qualified assessor, stated she would not deem the NR safe for medication self-management. Record review showed the NR's assessment was up-to-date.
5. Regulation show family contact is not required for a medication error but is for a change of condition. Record review and interview showed the facility contacted the NR's family appropriately when the NR had a change of condition and was sent to the hospital.

Conclusion / Action:

- [x] 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 #: 2055	Compliance Determination # 21896
Plan of Correction	BALLARD LANDMARK	Completion Date
Page 1 of 4	Licensee: BALLARD LANDMARK INN LLC	04/24/2023

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 03/30/2023 and 04/10/2023 of:

BALLARD LANDMARK
5433 LEARY AVENUE NW
SEATTLE, WA 98107

This document references the following complaint number(s): 76296, 74717, 74639

The following sample was selected for review during the unannounced on-site visit: 4 of 45 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Cathy Prentice, Complaint Investigator

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
4/27/2023 — 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.

EXECUTIVE DIRECTOR
4/28/2023

Administrator (or Representative)

4/28/23
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.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to have a safe medication delivery system for all 38 residents that received medication assistance. This failure caused a medication error for Resident 1 and placed 38 of 38 residents at risk of medication errors.

Findings included...

Record review from the website CEUfast.com, an accredited nursing continuing education provider, under the course Long-Term Care Nursing: Medication Pass showed the following, "Medication errors are serious and can cause resident harm or even death. It is human nature to want to simplify things when there is much to be done. In an attempt to do this, sometimes shortcuts are made. However, this is not good practice. ESPECIALLY when it comes to medications. Do not take shortcuts. More specifically, do NOT, under any circumstances, try to pre-pour medications to save time. Pre-pouring medications are against regulations. In addition, it increases the risk of making mistakes."

Record review showed the ALF admitted Resident 1 on [redacted]2022 with functional impairment due to a stroke (a disease that affects the arteries leading to and within the brain. A stroke occurs when a blood vessel that carries oxygen to the brain is either blocked by a clot or ruptures). Review of the Negotiated Service Agreement, dated [redacted]2022, showed the ALF's Medication Technicians (MT) would provide medication management and provide Resident 1's medications three times per day.

Review of an ALF Incident Report and Investigation Note (I&I), dated 03/15/2023, showed there had been a medication error involving Resident 1. The I&I stated Staff A (MT) gave Resident 1 another resident's medications on 03/15/2023 around 9:00PM. The I&I stated

Resident 1 was mistakenly given the following medications: tylenol 500mg (pain reliver), atorvastin 10mg (for cholesterol), clonazepam 1mg (sedative), gabapentin 100mg (nerve pain, anti-convulsant), primidone 50mg (anti-convulsant), tizandine 4mg (blood pressure). The I&I stated Resident 1, abound an hour after she was given the wrong medication, was found kneeling by her bed with uncontrollable restless leg movements, 911 was called and Resident 1 was sent to the hospital emergency room.

Review of the March 2023 Medication Administration Record (MAR) showed Resident 1 was supposed to receive the following medications at 8:00PM: atenolol 50mg for blood pressure, atorvastin 80mg (for cholesterol), Ducosate Plus 50mg (for constipation), famotidine 20mg (for reflux), gabapentin 100mg (nerve pain and anti-convulsant), and ropinirole 4 mg (for restless leg syndrome.) The MAR showed Staff A charted these medications as not given due to, "another resident's medications were given."

In an interview, on 04/10/2023 at 11:00 AM, the Director of Nursing Services (DNS) stated the ALF's standard practice for passing all residents medications was to pre-pour the medications into a plastic pouches and label with the residents name. The DNS stated that these pre-poured plastic pouches, for multiple residents, were then placed in a caddy basket to be delivered.

Observation, on 03/30/2023 at 11:00 AM, showed the ALF had a medication cart that held all of the residents labeled medications, in pharmacy packaging. The Medication Administration Record (MAR) that contained details of the residents' medication including the right drug, right route, right time and right dose was on a laptop computer mounted on the cart. The medication cart had wheels allowing it to be pushed to resident apartments for medication administration. In the medication cart were small clear pouches used to pre-pour medications into. The DNS and Staff B (MT) demonstrated how medications were removed from their pharmacy labeled containers and pre-poured in clear plastic pouches that were then labeled for the resident. The pre-poured plastic pouches, for multiple residents, were then placed in the plastic caddy to distribute without the MAR or pharmacy labels to refer to while providing medication assistance.

In an interview, on 04/10/2023 at 11:04 AM, Staff B stated she pre-poured medications in plastic pouches for multiple residents at a time and carried them in the plastic caddy to each residents' apartments. Staff B stated during a medication pass she may have pre-poured plastic pouches for up to 15 residents' medications at a time.

In an interview, on 04/10/2023 at 10:25 AM, Resident 1 stated after she received the wrong medications she felt funny, could not walk normally, and fell. Resident 1 stated she had felt, "more foggy in the brain" since the incident.

In interview, on 03/30/2023 at 11:00 AM, the DNS acknowledged that pre-pouring medication was not safe.

Statement of Deficiencies	License #: 2055	Compliance Determination # 21896
Plan of Correction	BALLARD LANDMARK	Completion Date
Page 4 of 4	Licensee: BALLARD LANDMARK INN LLC	04/24/2023

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) 6/8/2023 NE

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

Administrator (or Representative) 4/28/2023 Date