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

CRP/CSH Northgate LLC
NORTHGATE PLAZA
11030 NE 5TH AVE
SEATTLE, WA 98125

RE: NORTHGATE PLAZA License # 2374

Dear Administrator:

This letter addresses Compliance Determination(s) 38868 (Completion Date 03/28/2024) and 36044 (Completion Date 02/21/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/28/2024 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-2210-2

The Department staff who did the on-site verification:
Hayley Pinkham, ALF Licensor

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

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

Residential Care Services
Investigation Summary Report

Provider/Facility: NORTHGATE PLAZA
Provider Type: Assisted Living Facility
License/Cert.#: 2374
Compliance Determination #: 36044
Intake ID: 116281
Investigator: Hayley Pinkham
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 01/30/2024 through 02/21/2024
Complainant Contact Date(s):

Allegation(s):

1) The Named Resident (NR) reported having hallucinations to the Assisted Living Facility (ALF) staff. ALF staff investigated the concern and discovered the NR was receiving the wrong medication.

Investigation Methods:

Sample:
Total residents: 99
Resident sample size: 2
Closed records sample size:

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

Interviews:
Identified resident
Identified staff
Residents

Record Reviews:
Medical records
Incident investigation
Facility policies

Investigation Summary:

1) Interview with the NR showed the NR recalled receiving the wrong medication and reported "struggling" during the event. Interview and record review showed the ALF staff investigated the NR's concern when she reported symptoms related to her medication administration. Interview and record review showed the ALF staff substituted an incorrect medication to the NR for several weeks. Deficient practice identified.

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 #: 2374	Compliance Determination #:36044
Plan of Correction	NORTHGATE PLAZA	Completion Date
Page 1 of 4	Licensee: CRP/CSH Northgate LLC	02/21/2024

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 01/30/2024 and 01/30/2024 of:

NORTHGATE PLAZA
11030 NE 5TH AVE
SEATTLE, WA 98125

This document references the following complaint number(s): 112508, 116281

The following sample was selected for review during the unannounced on-site visit: 2 of 98 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Hayley Pinkham, ALF Licensor

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
2/22/2024 — 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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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Residential Care Services

Date

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Statement of Deficiencies	License #: 2374	Compliance Determination # 38044
Plan of Correction	NORTHGATE PLAZA	Completion Date
Page 2 of 4	Licensee: CRP/CSH Northgate LLC	02/21/2024

Administrator (or Representative) — Date: 2/23/2024

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:

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 2 resident (Resident 1) received medications as ordered. The failure caused Resident 1 harm when the ALF gave one medication as a substitute for another which resulted in withdrawal symptoms and discomfort.

Findings included...

Note: Review of the WebMD website showed triazolam is a benzodiazepine (benzodiazepines are central nervous system tranquilizer depressants that produce sedation and hypnosis, relieve anxiety, and muscle spasms, and reduce seizures). Triazolam would not be used as a pain reliever. Tramadol is a class of drug known as an opioid analgesic, used to help relieve moderate to moderately severe pain. Stopping triazolam suddenly would result in withdrawal and symptoms that could include muscle cramps, unpleasant feelings/sadness, sensitivity to light, uncontrollable shaking of part of the body, visual or auditory hallucinations, and seizures.

Record review of a Face Sheet showed the ALF admitted Resident 1 on [redacted] 2023 with multiple medically disabling diagnoses including [redacted]. Review of an Assessment, dated 12/15/2023, showed Resident 1 required the ALF to manage medications.

Record review of a December 2023 and January 2024 Medication Administration Record (MAR) showed Resident 1 had physician's orders for triazolam 0.25 milligram (mg) tab, every night at bedtime only. The MAR showed Resident 1 had a physician's order for tramadol 50 mg, take 1/2 tab every 6 hours as needed for left hip pain.

Administrator (or Representative) Date

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Record review of a "Medication Error Investigation", dated 01/25/2024, showed the ALF gave Resident 1 tramadol every night in substitute of the ordered triazolam starting on 12/19/2023. The investigation showed the error and was not caught and continued through 01/25/2024. The investigation noted Resident 1 experienced hallucinations on 01/25/2024 as a result of the medication error.

Observation, on 01/30/2024 at 3:25 PM, Staff B (Medication Technician - MT) demonstrated how MTs scanned medication through their MAR system before giving it to a resident. If the wrong medication was scanned, a red alert invalid warning would indicate the medication was incorrect. Staff B demonstrated how the red alert invalid warning was given when tramadol was scanned as a substitute for triazolam. Staff B demonstrated how the MT's had to manually override the MAR alert when they incorrectly gave tramadol instead of triazolam to Resident 1.

In an interview, on 01/30/2024 at 2:28 PM, Resident 1 confirmed the ALF staff had been giving her pain medication (tramadol) every night, in error, instead of the anti-anxiety medication (triazolam). Resident 1 stated she had trusted the medication given to her by the ALF staff was correct. Resident 1 stated she when she got the wrong medication (tramadol instead of triazolam) she had a, "very bad reaction." Because she did not get the anti-anxiety medication as prescribed, Resident 1 stated she experienced a rapid heart rate, and had struggled difficult breathing.

In an interview, on 01/30/2024 at 3:01 PM, Staff A (Wellness Nurse) stated she instructed the ALF MTs to substitute tramadol for triazolam. Staff A stated she thought the tramadol medication was a generic equivalent to triazolam. Staff A stated at the end of the workday, on 12/18/2023, a MT asked about the substitution because Resident 1's triazolam was out of supply and had not been refilled. Staff A stated she wasn't thinking properly, didn't look closely at the card of medication and said, "Yes."

In an interview, on 01/30/2024 at 3:25 PM, Staff B stated she had been the one who asked Staff A if tramadol could be substituted for triazolam. Staff B confirmed Staff A instructed them to substitute. Staff B stated the MAR system had showed the MT's that tramadol was "invalid" for triazolam however they continued giving the wrong medication and overriding the system on Staff A directive.

In an interview, on 02/21/2024 at 10:34 AM, Staff C (Executive Director) when asked if it was safe to substitute medications without an order, Staff C stated, "No, it is not." When asked if it was safe to substitute medications that did not treat the same condition, Staff C stated, "No". Staff C stated the ALF staff incorrectly substituted the tramadol for triazolam.

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In an interview, on 01/30/2024 at 3:01 PM, Staff A (Wellness Nurse) stated she instructed the ALF MTs to substitute tramadol for triazolam. Staff A stated she thought the tramadol medication was a generic equivalent to triazolam. Staff A stated at the end of the workday, on 12/18/2023, a MT asked about the substitution because Resident 1’s triazolam was out of supply and had not been refilled. Staff A stated she wasn’t thinking properly, didn’t look closely at the card of medication and said, “Yes.”

In an interview, on 01/30/2024 at 3:25 PM, Staff B stated she had been the one who asked Staff A if tramadol could be substituted for triazolam. Staff B confirmed Staff A instructed them to substitute. Staff B stated the MAR system had showed the MT’s that tramadol was “invalid” for triazolam however they continued giving the wrong medication and overriding the system on Staff A directive.

In an interview, on 02/21/2024 at 10:34 AM, Staff C (Executive Director) when asked if it was safe to substitute medications without an order, Staff C stated, “No, it is not.” When asked if it was safe to substitute medications that did not treat the same condition, Staff C stated, “No”. Staff C stated the ALF staff incorrectly substituted the tramadol for triazolam

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Plan of Correction	NORTHGATE PLAZA	Completion Date
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and had to manually override the MAR system to do so.

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, NORTHGATE PLAZA is or will be in compliance with this law and / or regulation on (Date) 3/7/2024 .

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

Michelle Wooster — Administrator (or Representative)

2/23/2024 — Date

and had to manually override the MAR system to do so.

Plan/Attestation Statement

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

Administrator (or Representative) Date