STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032-2388

February 12, 2020

NORMANDY PARK ASSISTED LIVING LLC
NORMANDY PARK ASSISTED LIVING
16625 1st Ave S
Burien, WA 98148

RE: NORMANDY PARK ASSISTED LIVING License #1688

Dear Administrator:

The Department completed a follow-up inspection of your assisted living facility on February 11, 2020 for the deficiency or deficiencies cited in the report/s dated September 18, 2019 and found no deficiencies.

The Department staff who did the follow-up inspection:
Pauline American Horse, Licensor

If you have any questions please, contact me at (253) 234-6020.

Sincerely,

James Sherman, Field Manager
Region 2, Unit D
Residential Care Services

Residential Care Services

Investigation Summary Report

Provider/Facility: NORMANDY PARK ASSISTED LIVING (686320) **Intake ID(s):** 3663941

License/Cert. #: AL1688

Investigator: Hayes, Mary **Region/Unit:** RCS Region 2/Unit D **Investigation Date(s):** 08/28/2019 through 09/17/2019

Complainant Contact Date(s): 08/21/2019, 09/04/2019

Allegations:

1.Named resident overdosed on a blood thinning medication.
2.Named resident was found unresponsive and half-dressed on her bed.
3.Un-named staff wasn't following process or procedure (medication administration).
4.Named resident was hospitalized and almost died.
5.Family had to stay at the hospital with named resident day and night.
6.Facility needs to be accountable for investigation and training related corrective actions.

Investigation Methods:

[X] **Sample:**	Named and 3 other residents on anticoagulant therapy	[X] **Observations:**	Environment, activities, staff-resident and resident-resident interactions, medication dispensing system and (medication) Cart #2 review
[X] **Interviews:**	Administrative, nursing, care and dining room staff, persons not affiliated with the facility	[X] **Record Reviews:**	Abuse/neglect policy and procedures, emergency response, named resident-related anticoagulation/Warfarin protocol, incident and investigation reports, assessment/care planning, hospital/laboratory results, physician orders

Residential Care Services

Investigation Summary Report

Allegation Summary:

1. Interviews and investigation records indicated named resident did not receive blood thinning medication as prescribed because staff did not follow medication administration procedures. Failed practice identified.
2. Interviews and record reviews were not consistent with observations and circumstances of the event. The facility followed their procedures for responding and activating their emergency response system, summoned medics for further assessment, transport and additional care and treatment. No failed practice.
3.Staff interviews and investigation record reviews, revealed named day-shift staff had not followed procedures by giving resident evening medications during dayshift. Failed facility practice identified.
4.A day after the medication error incident, named resident was hospitalized and treated for possible bleeding related to the medication error. There was no evidence named resident almost died.
5, Interviews indicated persons not affiliated with the facility chose to stay at the hospital. The hospital had not recommended or requested persons to stay. The Department has no jurisdiction for representative-related preferences and choices. No failed facility practice identified.
6. Once aware of the incident, the facility took immediate corrective action by contacting all interested parties including; the physician, representative, anti-coagulation clinic, pharmacy and the nursing staff. Completion of investigation determined a human error that included staff not implementing proper medication administration. All medication technician staff were trained and a new system for administering evening medications was implemented. Failed practice identified.

Unalleged Violation(s): ☐ **Yes** ☒ **No**

None.

Conclusion / Action: ☒ **Failed Provider Practice Identified / Citation(s) Written** ☐ **Failed Provider Practice Not Identified / No Citation Written**

Statement of Deficiency written for WAC 388-78A-2600(2)(I), completion date 09/18/19

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Statement of Deficiencies	License #: 1688	Completion Date
Plan of Correction	NORMANDY PARK ASSISTED LIVING	September 18, 2019
Page 1 of 4	Licensee: NORMANDY PARK ASSISTED LIVING LLC	

You are required to be in compliance at all times with all licensing laws and regulations to maintain your assisted living facility license.

This document references the following complaint numbers: 3663097 , 3663941

The department has completed data collection for the unannounced on-site complaint investigation on 8/28/2019 of:

NORMANDY PARK ASSISTED LIVING
16625 1st Ave S
Burien, WA 98148

The following sample was selected for review during the unannounced on-site complaint investigation : 4 of 64 current residents and 0 former residents.

The department staff that inspected and investigated the assisted living facility:

Mary Hayes, B.S.N, Licensor

From:

DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032-2388
(253)234-6020

As a result of the on-site complaint investigation 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.

James Hevra
Residential Care Services

09/25/19
Date

I understand that to maintain an assisted living facility license I must be in compliance with all the licensing laws and regulations at all times.

Janie Deuel
Administrator (or Representative)

10/2/2019
Date

RECEIVED
OCT 07 2019
DSHS/ALTSA/RCS

WAC 388-78A-2600 Policies and procedures.
(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:
(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290 ; sending medications with a resident when the resident leaves the premises;

This requirement was not met as evidenced by:
Based on interview and record review, the facility failed to ensure 1 of 3 medication technicians (Staff D), implemented the facility's procedures from the "Med-tech Training Standard" for safely administering medication, as prescribed, to Resident #1. This failure resulted in Resident #1 receiving at least, two additional doses of a blood thinning medication and placed her at risk for abnormal bleeding and subsequent hospitalization.

Findings included...

Review on 8/29/19, the undated "Medication Incident Standard" policy taken from the "Med-tech training Standard" document showed: Medication omissions and other medication incidents shall be reviewed, documented and make the necessary corrections for preventing further incidents. The policy showed the standard training guideline for medication administration included ensuring administration was the right resident, dose, frequency, route and time. A medication incident included: the wrong medication, wrong dose, wrong time, route, form and resident. The policy also included extra dosages and the omission of staff initials on the medication record, as incidents.

Resident #1's July 2019's Medication Administration Record (MAR) showed Resident #1 was admitted to the facility on [redacted]18, with multiple medical diagnosis including [redacted] and [redacted]. Review of her Assessment dated July 2019, showed Resident #1 required staff assistance with managing her medications, such as a blood thinning medication (Warfarin). Interview on 8/28/19 at 4:30 PM, showed Resident #1 was unable to verbalize what medications she took and whether she was offered or took more medication than what was prescribed.

Review of medications listed on Resident #1's July 2019 Medication Administration Record (MAR), included a physician's order for Warfarin-2.5 mg: take one tablet by mouth every evening at 7:00 PM, Saturday-Thursday and one half (or 1.25 mg) of tablet on Fridays.

Review of the "Medication Incident Report" dated 7/25/19, showed on 7/24 and 7/25/19 Resident #1 did not receive her blood thinning medication as prescribed, when Staff D, a medication technician scheduled for day-shift on 7/24 and 7/25/19, did not compare the blood-thinning medication orders on the medication card with medication orders entered into the computerized medication system. According to the incident report, the wrong time and two extra doses of a blood thinning medication was given in the morning, not the evening, as prescribed. There were no staff initials indicating the Warfarin was given in the morning and the omission of initials indicated a violation of the facility's Medication administration standards. [redacted]/19), Resident #1 exhibited changes in her behavior and was transferred to the hospital for weakness. She was hospitalized for 6 days with a low blood count (anemia), elevated blood-clotting times and active bleeding inside her stomach.

Review of Resident #1's Charting Notes written by Staff C, Resident Services Director, on

[redacted]19, revealed Resident #1 was hospitalized for a abnormal clotting times and bleeding. Additional charting notes dated [redacted]/19 revealed a "med error".

Review of hospital records dated [redacted]/19, showed Resident #1 was admitted with occult (hidden) blood loss, fatigue and weakness. After spending six days in the hospital, receiving blood, fluids and completing invasive/diagnostic testing, Resident #1 was discharged from the hospital and released back to the facility on [redacted]19 in stable condition.

Interviews on 8/28/19 between 9:00 a.m. and 2:30 p.m., included Staff A, Administrator, Staff B, Director of Nursing, Staff C, Resident Services Director, Staff D and F, Medication Technicians . Staff A, B, C, D, E and F became aware of a medication incident on 7/25/19 and determined Resident #1 did not receive her blood-thinning medications as prescribed when the count of the medications were not consistent with the prescription/order. Staff C determined Staff D had not followed the facility's policy or procedures for properly administering Resident #1's blood-thinning medication on 7/24 and 7/25/19 by giving the Warfarin in the morning (not evening) and by not initialing the medication record.

In interview on 8/28/19, at 10:30 AM with Staff F, when asked about the recent medication incident, Staff F stated that Resident #1 did not receive her medication as prescribed as it appeared Staff D did not follow procedures, like checking if it was the "right" time and comparing it to the medication order on the (bingo) card. Staff F stated that she would "call it an error".

In interview on 8/28/19 at 10:38 AM, Staff C stated that she conducted the investigation as soon as she was informed by Staff E that there was a discrepancy. Staff C said the investigation findings determined Staff D admitted that she gave Resident #1 evening medications during the day-shifts she worked on 7/24 and 7/25/19.

In interview on 8/28/19 at 3:05 PM, Staff D, stated that she had recently been ill, hospitalized and was taking prescribed medications that may have impaired her thinking on 7/24 and 7/25/19. Staff D stated she thought the blood-clotting medication was ordered to be given during day shift, not during the evening shift. Staff D remembered giving the medication sometime during the day on 7/24 and 7/25/19. She had no further recollection for not administering medications as prescribed or omitting her initials on those days. Staff D stated that it was her "mistake" and admitted Resident #1 did not get her medications, as prescribed on 7/24 and 7/25/19.

Interview on 9/5/19 at 3:05 PM, Staff E, an evening medication technician, stated during her evening medication pass on 7/24/19, she noted and reported a discrepancies between the number of available medications on the medication card (bubble-pack-system for the accounting of medications) and the 7:00 PM medication time, as listed on Resident #1's MAR. The blood thinning medication on the medication card had already been "punched-out" as if already administered, and there were no staff initials indicating the medication had already been given. Staff E immediately reported her findings to Staff B and Staff C.

In interview on 8/21/19 at 1:40 PM, a collateral contact stated that Resident #1 received additional doses of a blood-thinning medication that was not prescribed because someone administering medications did not follow procedures or protocols for administering medications as ordered. On 9/14/19 at 10:40 AM, collateral contact stated that Resident #1's health status

declined the day after extra doses of Warfarin were discovered as administered and after being hospitalized for 6 days.

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, NORMANDY PARK ASSISTED LIVING is or will be in compliance with this law and / or regulation on (Date) 10-15-2019 . In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

I understand that to maintain an assisted living facility license, the facility must be in compliance with the licensing laws and regulations at all times.

Jessie Heckel
Administrator (or Representative)

10-2-2019
Date