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

VLADIMER STEPANIA
VALLEY CARE ADULT FAMILY HOME
8213 S 116TH STREET
SEATTLE, WA 98178

RE: VALLEY CARE ADULT FAMILY HOME License # 327603

Dear Provider:

This letter addresses Compliance Determination(s) 55262 (Completion Date 02/19/2025) and 52691 (Completion Date 01/07/2025).

The Department completed a follow-up inspection of your Adult Family Home on 02/19/2025 and found that you have corrected the violations listed in the Full report dated 01/07/2025. Your home is back in compliance as of 02/10/2025 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10430-2-d, WAC 388-76-10430-2-c, WAC 388-76-10355-1, WAC 388-76-10355-2, WAC 388-76-10355-3, WAC 388-76-10355-4

The Department staff who did the on-site verification:
Olga Petrov, NCI

If you have any questions, please contact me at (253)234-6007.

Sincerely,

Dahl Kim

Dahl Kim, Field Manager
Region 2, Unit G
Residential Care Services

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Statement of Deficiencies	License #: 327603	Compliance Determination # 52691
Plan of Correction	VALLEY CARE ADULT FAMILY HOME	Completion Date
Page 1 of 5	Licensee: VLADIMER STEPANIA	01/07/2025

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for the unannounced on-site full inspection on 01/06/2025 and 01/06/2025 of:
VALLEY CARE ADULT FAMILY HOME
8213 S 116TH STREET
SEATTLE, WA 98178

The following sample was selected for review during the unannounced on-site visit: 2 of 6 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Olga Petrov, NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit G
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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.

Residential Care Services — 1-13-2025 Date

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

STATE OF WASHINGTON

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Residential Care Services

Date

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative) 1/21/2025 Date

WAC 388-76-10430 Medication system.

(2) When providing medication assistance or medication administration for any resident, the home must ensure each resident:

(c) Medication log is kept current as required in WAC 388-76-10475 ;

(d) Receives medications as required.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to have a medication system in place to ensure 1 of 2 sampled residents (Resident 1) received their medications as required, while meeting all laws and rules relating to medications. This failure placed Resident 1 at risk of worsening condition from not receiving medications as prescribed.

Findings included...

On 01/06/2025 at 12:45 PM, observation showed Resident 1 ambulated with the assistance of walker in the home and received total assistance from Staff C, Caregiver with medication administration.
In an interview on 01/06/2025 at 9:20 AM, Staff B, Caregiver stated that Resident 1 was nonverbal, and staff administer medications to the resident.

Review of the resident's records showed Resident 1's assessment dated 02/27/2024. It was documented that Resident 1 had diagnosis of [redacted]. Under medication management was documented that medications must be administered to the resident.

Review of Resident 1's January 2025 Medication Administration Record (MAR) showed they was on multiple medications requiring different regimen. It was documented Melatonin (medication helps with sleep disorder) 3 milligram (mg) with direction to take 3 tablets (9 mg) by month daily at bedtime for insomnia and was initialed by Staff B, Caregiver and Staff F, Caregiver as given from 01/01/2025-01/05/2025.

On 01/06/2025 at 11:11 AM, observation of the home supply of Resident 1's medications showed a bottle of over-the-counter Melatonin 1 mg. On the side of the bottle was a sticky note with the resident's first name and "3 mg. 8 pm- bedtime" written on it.

Provider (or Representative) Date

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Findings included…

On 01/06/2025 at 12:45 PM, observation showed Resident 1 ambulated with the assistance of walker in the home and received total assistance from Staff C, Caregiver with medication administration.
In an interview on 01/06/2025 at 9:20 AM, Staff B, Caregiver stated that Resident 1 was nonverbal, and staff administer medications to the resident.

Review of the resident's records showed Resident 1's assessment dated 02/27/2024. It was documented that Resident 1 had diagnosis of [redacted] ([redacted]), [redacted]. Under medication management was documented that medications must be administered to the resident.

Review of Resident 1's January 2025 Medication Administration Record (MAR) showed they was on multiple medications requiring different regimen. It was documented Melatonin (medication helps with sleep disorder) 3 milligram (mg) with direction to take 3 tablets (9 mg) by month daily at bedtime for insomnia and was initialed by Staff B, Caregiver and Staff F, Caregiver as given from 01/01/2025-01/05/2025.

On 01/06/2025 at 11:11 AM, observation of the home supply of Resident 1's medications showed a bottle of over-the-counter Melatonin 1 mg. On the side of the bottle was a sticky note with the resident's first name and "3 mg. 8 pm- bedtime" written on it.

In an interview on 01/06/2025 at 11:13 AM, when asked how many tablets of Melatonin to the resident was given, Staff B, Caregiver stated that they gave 3 tablets of 1 mg of Melatonin. Department staff asked Staff B to read directions on MAR. Staff B after reading, stated that the home should be giving 9 pills of 1 mg of Melatonin. Staff B stated that the resident previously had a bottle of 3 mg of Melatonin before and added that they did not know when the new bottle of 1 mg of Melatonin started.

Review of December 2024 MAR showed Melatonin 3 mg- take 3 tabs daily at bedtime for 30 days for insomnia and initialed by Staff B and Staff F as given from 12/01/2024-12/31/2024.

In an interview on 01/06/2025 at 11:21 AM, Staff A, Provider was asked how much Melatonin was given to Resident 1, Staff A, checked the MAR and stated, "three tablets." Department staff pointed to the Melatonin strength on the Resident 1's MAR and on the medication's bottle to the Staff A, and they stated caregivers should have given 9 tablets of Melatonin 1 mg to Resident 1. Staff A stated that caregivers gave the wrong dose of Melatonin to Resident 1.

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, VALLEY CARE ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on (Date) 1/6/2025.

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

V. [signature] — Provider (or Representative)

1/13/2025 — Date

WAC 388-76-10355 Negotiated care plan. The adult family home must use the resident assessment and preliminary care plan to develop a written negotiated care plan. The home must ensure each resident's negotiated care plan includes:

(1) A list of the care and services to be provided;

(2) Identification of who will provide the care and services;

(3) When and how the care and services will be provided;

(4) How medications will be managed, including how the resident will get their medications when the resident is not in the home;

In an interview on 01/06/2025 at 11:13 AM, when asked how many tablets of Melatonin to the resident was given, Staff B, Caregiver stated that they gave 3 tablets of 1 mg of Melatonin. Department staff asked Staff B to read directions on MAR. Staff B after reading, stated that the home should be giving 9 pills of 1 mg of Melatonin. Staff B stated that the resident previously had a bottle of 3 mg of Melatonin before and added that they did not know when the new bottle of 1 mg of Melatonin started.

Review of December 2024 MAR showed Melatonin 3 mg- take 3 tabs daily at bedtime for 30 days for insomnia and initialed by Staff B and Staff F as given from 12/01/2024-12/31/2024.

In an interview on 01/06/2025 at 11:21 AM, Staff A, Provider was asked how much Melatonin was given to Resident 1, Staff A, checked the MAR and stated, “three tablets.” Department staff pointed to the Melatonin strength on the Resident 1’s MAR and on the medication’s bottle to the Staff A, and they stated caregivers should have given 9 tablets of Melatonin 1 mg to Resident 1. Staff A stated that caregivers gave the wrong dose of Melatonin to Resident 1.

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_____ _____

Provider (or Representative) Date

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(2) Identification of who will provide the care and services;

(3) When and how the care and services will be provided;

(4) How medications will be managed, including how the resident will get their medications when the resident is not in the home;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to include in the Negotiated Care Plan (NCP) of 1 of 2 residents (Resident 1) who provided medication administration assistance and when and how the assistance were provided. This placed Resident 1 at risk of unmet needs.

Findings included…

On 01/06/2025 at 12:45 PM, observation showed Resident 1 ambulated with the assistance of walker in the home. Resident 1 received total assistance from Staff C, Caregiver with medication administration, toileting, and required cueing with mobility and eating.

In an interview on 01/06/2025 at 9:20 AM, Staff B, Caregiver stated that Resident 1 was nonverbal, had diagnosis of [redacted] ([redacted]). Staff B stated that caregivers were checking the resident's BS before breakfast and dinner injecting Insulin (medication used to treat high BS) Lantus (injectable diabetes medicine)-20 U (units) every morning and Trulicity (injectable Diabetic medication) 0.75 milligram (mg) once a week. Staff B stated that Resident 1 needed assistance with toileting.

Resident 1's annual assessment dated 02/27/2024 was reviewed. This record showed Resident 1 had Insulin dependent Diabetes, a cognition impairment and made poor decisions. Under medication management was documented that medications must be administered to the resident. It was indicated that the resident was on "complex regimen, cannot use syringe, does not follow frequency or dosage, Poor coordination, forgets to take medications, Unable to read/see labels, Unaware of dosages." Resident 1 required blood glucose monitoring and insulin injections through nurse delegation (the tasks are performed as instructed and supervised by the delegating nurse). The record also showed that the resident required diabetic foot care.

Review of Resident 1's January 2025 medication administration record showed they were on multiple medication.

A review of Resident 1's NCP dated 02/10/2024, under "Medication management," showed a mark in the box "administration" and beneath it was a note written: "Open medication container and dispense medication in enabler (medicine cup)." There was a check mark under "Delegation needed" and written notes, "Delegation required at this time of Assessment." There was no documentation of how and when the resident's medications were managed, and by whom.

Further review of Resident 1's assessment dated 02/27/2024 showed they used a walker for their ambulation and needed extensive assistance with outside mobility and

toilet use. It was indicated that Resident 1 required cueing with completing eating tasks.

Review of 02/10/2024 Resident 1's NCP under ambulation/ mobility was mark independent and was indicated the resident used a wheelchair. Under indoor/outdoor mobility, eating, and toileting was marked the resident was independent. There were no specifics of how the resident's activities of daily living would be managed, and by whom.

In an interview on 01/06/2025 at 10:57 AM, Staff A stated that the home used a new NCP form and needed to update the NCP.

Attestation Statement

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

V. Stepania — Provider (or Representative)

1/21/2025 — Date

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