STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave, Suite 200, Vancouver, WA 98684

STEVENSON GROUP INC
BETTER OPTIONS FOR ELDER CARE
15214 NE 25TH CIR
VANCOUVER, WA 98684

RE: BETTER OPTIONS FOR ELDER CARE License # 64503

Dear Provider:

This letter addresses Compliance Determination(s) 52746 (Completion Date 01/08/2025) and 49624 (Completion Date 11/07/2024).

The Department completed a follow-up inspection of your Adult Family Home on 01/08/2025 and found that you have corrected the violations listed in the Complaint report dated 11/07/2024. Your home is back in compliance as of 11/30/2024 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 388-76-10616-1-a, WAC 388-76-10616-1-b, WAC 388-76-10616-1-c, WAC 388-76-10616-1-d, WAC 388-76-10616-3

The Department staff who did the off-site verification:
Priscilla Changa, Nursing Home Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit F
Residential Care Services

STATE OF WASHINGTON
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800 NE 136th Ave, Suite 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 64503	Compliance Determination # 49624
Plan of Correction	BETTER OPTIONS FOR ELDER CARE	Completion Date
Page 1 of 3	Licensee: STEVENSON GROUP INC	11/07/2024

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 an unannounced on-site complaint investigation on 10/31/2024 and 11/07/2024 of:

BETTER OPTIONS FOR ELDER CARE
15214 NE 25TH CIR
VANCOUVER, WA 98684

This document references the following complaint number(s): 153415

The following sample was selected for review during the unannounced on-site visit: 2 of 7 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Priscilla Changa, Nursing Home Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit F
800 NE 136th Ave, Suite 200
Vancouver, WA 98684

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

11.13.2024

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.

FStevenson
Provider (or Representative)

11/17/2024
Date

WAC 388-76-10616 Resident rights Transfer and discharge notice.

(1) Before a home transfers or discharges a resident, the home must give the resident and the resident's representative a written thirty day notification informing them of the transfer or discharge. The home must also make a reasonable effort to notify, if known, any interested family member. The written notification must be in a language and manner the resident understands and include the following:

(a) The reason for transfer or discharge;

(b) The effective date of transfer or discharge;

(c) The location where the resident is transferred or discharged if known at the time of the thirty-day discharge notice;

(d) The name, address, and telephone number of the state long-term care ombuds;

(3) A copy of the written notification must be in the resident's records.

This requirement was not met as evidenced by:

Based on interview and record review the home failed to issue and/or obtain consent from residents' representative to transfer the resident to another facility for 1 of 1 sampled resident (Resident 1/R1) reviewed for transfer and discharge rights. This failure caused R1 to have their rights violated and placed R1 at risk of emotional distress.

Findings included...

Record review of R1's medical records showed R1 was admitted to the home on [redacted]/2022 with diagnosis including [redacted] and had a Power of Attorney (POA) in place.

Record review of an email sent to the Department on 09/19/2024 at 9:12 AM showed R1 was moved to another facility on [redacted]/2024.

Record review of R1's medical records did not show consent and/or a transfer notice was issued to the POA.

During an interview on 10/31/2024 at 09:56 AM, Staff B, Resident Care Manager, stated that R1 was transferred from the AFH's sister facility but was unsure of the date and if transfer notice was issued. Staff B stated that the provider handled the transfer

Provider (or Representative) _____ Date _____

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Record review of R1's medical records did not show consent and/or a transfer notice was issued to the POA.

During an interview on 10/31/2024 at 09:56 AM, Staff B, Resident Care Manager, stated that R1 was transferred from the AFH's sister facility but was unsure of the date and if transfer notice was issued. Staff B stated that the provider handled the transfer

notification to family members.

During an interview on 10/31/2024 at 2:15 PM, Collateral Contact 1 (CC1) stated they were not notified and did not consent to R1's move to another facility. CC1 stated they were made aware of the transfer when they went to visit R1 at their previous home and was told they had moved R1 to another home. CC1 stated that they were not notified of R1's hospitalization; they were made aware when hospital called them to obtain consent for treatment.

During an interview on 11/01/2024 at 4:11 PM, Staff A, Provider, stated that it was expected that staff were to obtain consent prior to transferring residents to another facility. Staff A said they were not aware they needed to issue a transfer notice when residents moved to one of their sister facilities. Staff A stated that it was expected for staff to immediately notify resident representative during or right after the resident was transferred to the hospital. Staff A indicated a transfer notice should have been issued and staff should have made notification to residents' representative when R1 transferred to the hospital.

Review of a voicemail recording received by the Department on 11/04/2024 at 4:16 PM, Staff A stated that the home did not notify R1's representative of the transfer to another facility.

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, BETTER OPTIONS FOR ELDER CARE is or will be in compliance with this law and / or regulation on (Date) 11/30/2024.

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

F Stevenson
Provider (or Representative)

11/17/2024
Date

notification to family members.

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During an interview on 11/01/2024 at 4:11 PM, Staff A, Provider, stated that it was expected that staff were to obtain consent prior to transferring residents to another facility. Staff A said they were not aware they needed to issue a transfer notice when residents moved to one of their sister facilities. Staff A stated that it was expected for staff to immediately notify resident representative during or right after the resident was transferred to the hospital. Staff A indicated a transfer notice should have been issued and staff should have made notification to residents' representative when R1 transferred to the hospital.

Review of a voicemail recording received by the Department on 11/04/2024 at 4:16 PM, Staff A stated that the home did not notify R1's representative of the transfer to another facility.

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_____ _____

Provider (or Representative) Date