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

VIORICA CAPRAR
SENIOR CARE ADULT FAMILY HOME
26609 199TH PL SE
COVINGTON, WA 98042

RE: SENIOR CARE ADULT FAMILY HOME License # 750067

Dear Provider:

This letter addresses Compliance Determination(s) 32077 (Completion Date 11/14/2023) and 22111 (Completion Date 06/01/2023).

The Department completed a follow-up inspection of your Adult Family Home on 11/14/2023 and found that you have corrected the violations listed in the Complaint report dated 06/01/2023. Your home is back in compliance as of 04/05/2023 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 388-76-10485-1, WAC 388-76-10135-3-b, WAC 388-76-10135-3-b-i, WAC 388-76-10135-3-b-ii

The Department staff who did the on-site verification:
Marites Gatan, NCI

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

Sincerely,

Lydia Owusu-Acheampong, Field Manager
Region 2, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: SENIOR CARE ADULT FAMILY HOME
License/Cert.#: 750067
Compliance Determination #: 22111
Investigator: Zwelithini Mabhena
Provider Type: Adult Family Home
Intake ID: 77075
Region/Unit #: RCS Region 2 / Unit G
Investigation Date(s): 04/04/2023 through 06/01/2023
Complainant Contact Date(s): 04/04/2023

Allegation(s):

1. The Named Resident's (NR) spouse was turned away from being admitted to the Adult Family Home (AFH).
2. The AFH called NR's Collateral Contact (CC) to come and get them because NR was too much trouble to care for.
3. NR was given a double dose of a medication.
4. NR reported AFH staff would not take them to the bathroom.
5. The AFH provider was angry that NR pulled a table cloth of a table while trying to get up and moved their shoes around the floor.
6. The AFH had an 80 year old woman running the AFH .
7. NR was locked in their room for several hours after asking to use the bathroom.

Investigation Methods:

Sample:	Total residents: 4 Resident sample size: 1 Closed records sample size: 1
Observations:	General Adult Family Home (AFH) environment. Staff/resident interactions Resident/resident interactions
Interviews:	AFH Staff AFH residents AFH Provider
Record Reviews:	NR Negotiated Care Plan (NCP) NR Assessment Progress notes Incident log Staff Background checks Abuse Neglect policy Medication administration records (MAR)

Investigation Summary:

1. Interviews with the AFH provider revealed that they were not fully informed of NR's spouse limitations that the AFH could not accommodate. The AFH provider stated the

resident was turned away to be placed in an AFH that could better care for the resident. Review of the regulatory requirement showed the AFH was compliant with State regulation.
2. Interviews with the AFH provider revealed the resident verbalized that they did not want to be at the home and wanted to be close their spouse. AFH provider stated NR's CC was notified and who insisted taking them home. AFH provider stated a 30-day notice was not issued as a result.
3. In an interview the AFH provider stated NR was in the home for one night only before the family picked them up. the AFH provider stated NR was not overmedicated and had records to provide to show that. Review of the records showed medication was not given outside of the prescribed times. Other residents interviewed did not reveal any medication concerns.
4. In an interview the AFH provider stated they never refused to assist NR to the bathroom. Interviews with other AFH residents did not reveal any incidences of being denied assistance to the bathroom.
5. In an interview the AFH provider stated they did not recall any incidences of them getting angry at the resident. The AFH provider stated that because of their heavy accent they were perceived as being angry. Interviews with other residents did not reveal any verbal altercations with staff or the AFH provider. Review of the records did not reveal any incidences.
6. In an interview the AFH provider stated they were not running a boarding facility. Interviews with other residents who had been in the AFH stated they had no knowledge of this with no additional concerns for safety, neglect, or abuse.
7. In an interview the AFH provider stated that all bedroom doors at the AFH were lockable from the inside only. AFH provider stated staff had door keys to open the doors in case of emergencies or general resident checks. Other resident interviews did not reveal any concerns about being locked in their rooms or any other types of abuse. Unable to substantiate if the incident occurred. Records reviewed did not show any concerns.

-An unalleged violation was observed and cited at, WAC 388-76-10485(1) Medication Storage, WAC 388-76-10430(1) Medication System and WAC 388-76-10135 Caregiver qualifications (b)(i)(ii) . Please refer to Statement of Deficiency dated 06/01/2023 for more information.

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 #: 750067	Compliance Determination # 22111
Plan of Correction	SENIOR CARE ADULT FAMILY HOME	Completion Date
Page 1 of 5	Licensee: VIORICA CAPRAR	06/01/2023

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 04/04/2023, 04/04/2023 and 04/04/2023 of:

SENIOR CARE ADULT FAMILY HOME
26609 199TH PL SE
COVINGTON, WA 98042

This document references the following complaint number(s): 76821, 77169, 77075

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

The department staff that investigated the Adult Family Home:

Zwelithini Mabhena, AFH Licensor

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 — 06/06/2023 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) 07-12-2023 Date

WAC 388-76-10485 Medication storage. The adult family home must ensure all prescribed and over-the-counter medications are stored:

(1) In locked storage;

This requirement was not met as evidenced by:

Based on observation and interview the Adult Family Home (AFH) failed to ensure medications for 4 of 4 residents (Residents 1, 2, 3, and 4) were stored in a locked storage. This failure placed all four residents at risk for medication administration errors and medication safety concerns.

Findings included...

On 04/04/2023 at 4:58 PM, observed Residents 1, 2, 3 and 4 in the home. Residents 1, 2 and 3 ambulated independently while Resident 4 was observed lying in bed.

In an interview on 04/04/2023 at 4:59 PM, Staff B, Caregiver who was present in the AFH with Residents 1, 2, 3 and 4 could not respond to questions because of limited English.

During an onsite observation on 04/04/2023 at 4:59 PM, four medication cups were observed sitting on top of a black file cabinet located in the AFH dining room. A closer observation showed the medication cups were labeled with each of the 4 residents 1st names, had various pills with different shapes and colors in them. Some of the drawers of the file cabinet were slightly open and had various medication bottles and pill cards that could be seen stored in the unlocked cabinet.

In an interview on 04/04/2023 at 5:09 PM, Resident 1 stated the medications sitting on top of the file cabinet was how the AFH staff prepared their medications to be administered prior to the evening meal service daily.

In a phone interview on 04/05/2023 at 12:27 PM, Staff A, Entity Representative stated the file cabinet was used to store resident medications. Staff A stated the medications sitting on top of the file cabinet were medications that were ready to be given before dinner service. Staff A was made aware of the regulatory requirement on leaving medications unattended and to have all medications stored in a locked storage container.

Attestation Statement

Statement of Deficiencies	License #: 750067	Compliance Determination # 22111
Plan of Correction	SENIOR CARE ADULT FAMILY HOME	Completion Date
Page 3 of 5	Licensee: VIORICA CAPRAR	06/01/2023

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, SENIOR CARE ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on (Date) 04-05-2023

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

Provider (or Representative) — Date: 07-12-2023

WAC 388-76-10430 Medication system.

(1) If the adult family home admits residents who need medication assistance or medication administration services by a legally authorized person, the home must have systems in place to ensure the services provided meet the medication needs of each resident and meet all laws and rules relating to medications.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Adult Family Home (AFH) failed to ensure that 1 of 1 caregiver (Staff B, Caregiver) was able to understand and speak enough basic English to communicate. This failure placed 4 of 4 residents (Residents 1, 2, 3 and 4) at risk for unmet care needs, and diminished quality of care.

Findings included...

On 04/04/2023 at 4:58 PM, observed Residents 1, 2, 3 and 4 in the home. Residents 1, 2 and 3 ambulated independently while Resident 4 was observed lying in bed. Staff B was the only staff member present.

On 04/04/2023 at 4:59 PM, observed four medication cups sitting on top of a black file cabinet located in the AFH dining room. A closer observation showed the medication cups were labeled with each of the 4 residents 1st names, had various pills with different shapes and colors in them. Some of the drawers of the file cabinet were slightly open and had various medication bottles and pill cards that could be seen stored in the unlocked cabinet.

In an interview on 04/04/2023 at 5:01 PM, Staff B, was asked how the unattended medications sitting on the file cabinet were to be kept. Staff B stated that, they did not understand English.

In an interview on 04/04/2023 at 5:09 PM, Resident 1 stated the medications sitting on top of the file cabinet was how the AFH staff prepared their medications to be administered prior to the evening meal service daily.

In a telephone interview on 06/01/2023 at 11:41 AM, Staff A, Entity Representative stated that Staff B spoke English but may have been nervous.

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, SENIOR CARE ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on
(Date) 04-05-2023

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

Fleyrat — Provider (or Representative)

07-12-2023 — Date

WAC 388-76-10135 Qualifications Caregiver. The adult family home must ensure each caregiver has the following minimum qualifications:

(3) Has basic communication skills to:

(b) Understand and speak English well enough to:

(i) Respond appropriately to emergency situations; and

(ii) Read, understand, and implement resident negotiated care plans;

This requirement was not met as evidenced by:

Based on interview and record review the Adult Family Home (AFH) failed to ensure that 1 of 1 caregiver (Staff B, Caregiver) was able to understand and speak enough basic English to communicate . This failure placed 4 of 4 residents (Residents 1, 2, 3 and 4) at risk for unmet care needs, and diminished quality of care.

Findings included...

On 04/04/2023 at 4:58 PM, observed Residents 1, 2, 3 and 4 in the home. Residents 1, 2 and 3 ambulated independently while Resident 4 was observed lying in bed. Staff B caregiver was the only staff member present.

During an onsite observation on 04/04/2023 at 4:59 PM, four medication cups were observed sitting on top of a black file cabinet located in the AFH dining room. A closer observation showed the medication cups were labeled with each of the 4 residents 1st names, had various pills with different shapes and colors in them. Some of the drawers of the file cabinet were slightly open and had various medication bottles and pill cards that could be seen stored in the unlocked cabinet.

In an interview on 04/04/2023 at 5:01 PM, Staff B, Caregiver was asked how the unattended medications sitting on the file cabinet were to be kept and stated that they did not understand English.

In a telephone interview on 06/01/2023 at 11:41 AM, Staff A, Entity Representative stated that Staff B spoke English but may have been nervous because of Department staff presence.

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, SENIOR CARE ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on (Date) 06-01-2023.

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

V Caprar — Provider (or Representative)

07-12-2023. — Date