



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

MARGARET IGBEKOYI
MAGGIES AFH
805 S 309TH PLACE
FEDERAL WAY, WA 98003

RE: MAGGIES AFH License # 750596

Dear Provider:

This letter addresses Compliance Determination(s) 50751 (Completion Date 11/25/2024) and 46824 (Completion Date 09/26/2024).

The Department completed a follow-up inspection of your Adult Family Home on 11/25/2024 and found that you have corrected the violations listed in the Full report dated 09/26/2024. Your home is back in compliance as of 10/30/2024 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 388-76-10165-1-a, WAC 388-76-10285, WAC 388-76-10285-1, WAC 388-76-10285-2, WAC 388-76-10355-7-b, WAC 388-76-10355-7-a, WAC 388-76-10380, WAC 388-76-10380-4, WAC 388-76-10400-3-b, WAC 388-76-10430-2-d, WAC 388-76-10430-2-c, WAC 388-76-10485-1, WAC 388-76-10490-1, WAC 388-76-10685-11

The Department staff who did the on-site verification:

Michele Grumke, AFH Licenser

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

This document was prepared by Residential Care Services for the Locator website.



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

Statement of Deficiencies	License #: 750596	Compliance Determination # 46824
Plan of Correction	MAGGIES AFH	Completion Date
Page 1 of 14	Licensee: MARGARET IGBEKOYI	09/26/2024

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 the unannounced on-site full inspection on 09/06/2024 and 09/06/2024 of:

MAGGIES AFH
805 S 309TH PLACE
FEDERAL WAY, WA 98003

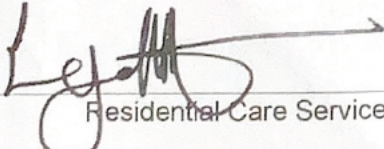
The following sample was selected for review during the unannounced on-site visit: 2 of 2 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Michele Grumke, AFH Licenser

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

10-1-2024
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.

This document was prepared by Residential Care Services for the Locator website.



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

Statement of Deficiencies	License #: 750596	Compliance Determination # 46824
Plan of Correction	MAGGIES AFH	Completion Date
Page 1 of 14	Licensee: MARGARET IGBEKOYI	09/26/2024

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 the unannounced on-site full inspection on 09/06/2024 and 09/06/2024 of:

MAGGIES AFH
805 S 309TH PLACE
FEDERAL WAY, WA 98003

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

The department staff that inspected the Adult Family Home:

Michele Grumke, AFH Licenser

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

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.

This document was prepared by Residential Care Services for the Locator website.

Margaret Kokoro
Provider (or Representative)

10/10/24
Date

WAC 388-76-10165 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The adult family home must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for each individual listed in WAC 388-76-10161 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure there was a valid Washington State name and date of birth Background Inquiry (BGI) for 2 of 3 sampled staff (Staff A, Provider, and Staff B, Caregiver). This failure placed both residents (Resident 1 and Resident 2) at risk of harm from staff with an unknown current criminal background.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 1 and Resident 2 lived in and received care from the AFH. Further review showed Staff A worked in the AFH.

Review of Staff A's personnel records showed the AFH was licensed on 08/27/2007. Further review showed a BGI background check that expired on 04/05/2024.

Review of Staff B's personnel records showed a date of hire of 02/08/2008. Further review showed a BGI background check that expired on 04/05/2024.

In an interview on 09/06/2024 at 4:22 PM, Staff A stated that they had completed the BGI background checks for themselves and Staff B. Staff A further stated that they may not have clicked a button to complete the transaction.

Attestation Statement

This document was prepared by Residential Care Services for the Locator website.

Provider (or Representative)

Date

WAC 388-76-10165 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The adult family home must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for each individual listed in WAC 388-76-10161 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure there was a valid Washington State name and date of birth Background Inquiry (BGI) for 2 of 3 sampled staff (Staff A, Provider, and Staff B, Caregiver). This failure placed both residents (Resident 1 and Resident 2) at risk of harm from staff with an unknown current criminal background.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 1 and Resident 2 lived in and received care from the AFH. Further review showed Staff A worked in the AFH.

Review of Staff A's personnel records showed the AFH was licensed on 08/27/2007. Further review showed a BGI background check that expired on 04/05/2024.

Review of Staff B's personnel records showed a date of hire of 02/08/2008. Further review showed a BGI background check that expired on 04/05/2024.

In an interview on 09/06/2024 at 4:22 PM, Staff A stated that they had completed the BGI background checks for themselves and Staff B. Staff A further stated that they may not have clicked a button to complete the transaction.

Attestation Statement

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies

License #: 750596

Compliance Determination # 46824

Plan of Correction

MAGGIES AFH

Completion Date

Page 3 of 14

Licensee: MARGARET IGBEKOYI

09/26/2024

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date) 9/17/24.

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

Margaret Igbekeyi
Provider (or Representative)

10/10/24
Date

WAC 388-76-10285 Tuberculosis Two step skin testing. Unless the person meets the requirement for having no skin testing or only one test, the adult family home, choosing to do skin testing, must ensure that each person has the following two-step skin testing:

- (1) An initial skin test within three days of employment; and
- (2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure 1 of 3 sampled staff (Staff C, Caregiver) had an initial Tuberculosis (TB), a bacterial infection that affects the lungs and can be fatal without treatment, skin test completed within 3 days of hire and a second skin test completed 1 to 3 weeks after the first. This failure placed all residents and staff in the AFH at risk of possible exposure to TB.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 1 and Resident 2 lived in and received care from the AFH.

During an interview on 09/06/2024 at 9:01 AM, Staff A, Provider, stated that Staff C worked full time and lived in the AFH.

Review of Staff C's personnel records showed a hire date of 04/05/2023. Further review showed a negative TB skin test result dated 04/23/2021 and there were no TB skin test results for a second test. Additionally, Staff C's records showed a chest x-ray result dated 05/31/2021 that was negative for TB.

In an interview on 09/06/2024 at 2:21 PM, Staff A stated that Staff C's TB skin test result was negative but appeared slightly red. Staff A further stated that they had decided to

This document was prepared by Residential Care Services for the Locator website.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date)_____.

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

Provider (or Representative)

Date

WAC 388-76-10285 Tuberculosis Two step skin testing. Unless the person meets the requirement for having no skin testing or only one test, the adult family home, choosing to do skin testing, must ensure that each person has the following two-step skin testing:

- (1) An initial skin test within three days of employment; and
- (2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure 1 of 3 sampled staff (Staff C, Caregiver) had an initial Tuberculosis (TB), a bacterial infection that affects the lungs and can be fatal without treatment, skin test completed within 3 days of hire and a second skin test completed 1 to 3 weeks after the first. This failure placed all residents and staff in the AFH at risk of possible exposure to TB.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 1 and Resident 2 lived in and received care from the AFH.

During an interview on 09/06/2024 at 9:01 AM, Staff A, Provider, stated that Staff C worked full time and lived in the AFH.

Review of Staff C's personnel records showed a hire date of 04/05/2023. Further review showed a negative TB skin test result dated 04/23/2021 and there were no TB skin test results for a second test. Additionally, Staff C's records showed a chest x-ray result dated 05/31/2021 that was negative for TB.

In an interview on 09/06/2024 at 2:21 PM, Staff A stated that Staff C's TB skin test result was negative but appeared slightly red. Staff A further stated that they had decided to

send Staff C for a chest x-ray.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date) 10/25/24.

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

Margaret Kobina
Provider (or Representative)

10/10/24
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:

(7) If needed, a plan to:

- (a) Follow in case of a foreseeable crisis due to a resident's assessed needs;
- (b) Reduce tension, agitation and problem behaviors;

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 development of 1 of 2 sampled residents (Resident 1) Negotiated Care Plan (NCP), the resident's problem behaviors and interventions. These failures placed Resident 1 at risk of unmet care needs.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 1 lived in and received care from the AFH.

Review of Resident 1's NCP dated 01/26/2023 showed Resident 1 was admitted to the AFH on [REDACTED]/2022. Further review showed Resident 1's NCP Psych/Social/Cognitive Status section had no documentation for memory impairment both short- and long-term memory, decision making, depression, anxiety, and required psychopharmacological medication (medications used to treat mental health disorders).

send Staff C for a chest x-ray.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date)_____.

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

Provider (or Representative)

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:

(7) If needed, a plan to:

(a) Follow in case of a foreseeable crisis due to a resident's assessed needs;

(b) Reduce tension, agitation and problem behaviors;

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 development of 1 of 2 sampled residents (Resident 1) Negotiated Care Plan (NCP), the resident's problem behaviors and interventions. These failures placed Resident 1 at risk of unmet care needs.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 1 lived in and received care from the AFH.

Review of Resident 1's NCP dated 01/26/2023 showed Resident 1 was admitted to the AFH on [REDACTED]/2022. Further review showed Resident 1's NCP Psych/Social/Cognitive Status section had no documentation for memory impairment both short- and long-term memory, decision making, depression, anxiety, and required psychopharmacological medication (medications used to treat mental health disorders).

Review of Resident 1's September 2024 pharmacy-generated Medication Administration Record (MAR) showed Resident 1 was prescribed Olanzapine 20 milligram (mg), take 1 tablet by mouth at bedtime for mood disorder.

In an interview on 09/06/2024 at 9:25 AM, Staff A, Provider, stated that Resident 1 was very picky when it came to food.

Review of Resident 1's Assessment dated 03/31/2023 showed Resident 1 had multiple major mental health diagnosis that led the resident to exhibit multiple behaviors. Assessment showed Resident 1 required the AFH to assist with problem solving, resolving disagreements, provide the resident with time and space when irritated, and to assist with managing obsessive/repetitive behaviors. Resident 1's Assessment showed the resident had issues with short-term memory which required the AFH to answer the residents' repetitive questions, provide them with information on the plans for the day, and write down a schedule. The Assessment showed Resident 1 was very selective with what they ate and enjoyed pork chops, peanut butter and jelly sandwiches, and meatloaf. In addition, Resident 1 was unwilling to eat vegetables and most fruits and required assistance in managing a balanced diet.

In an interview on 09/06/2024 at 11:56 AM, Staff A stated that they may have forgotten to write in behaviors and interventions on Resident 1's NCP.

In an exit interview on 09/06/2024 at 4:19 PM, Staff A stated that Resident 1 opened and closed their window so often that it had to be replaced.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date) 10/21/24.

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

Margaret Koko
Provider (or Representative)

10/10/24
Date

WAC 388-76-10380 Negotiated care plan Timing of reviews and revisions. The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:

(4) At least every twelve months.

Review of Resident 1's September 2024 pharmacy-generated Medication Administration Record (MAR) showed Resident 1 was prescribed Olanzapine 20 milligram (mg), take 1 tablet by mouth at bedtime for mood disorder.

In an interview on 09/06/2024 at 9:25 AM, Staff A, Provider, stated that Resident 1 was very picky when it came to food.

Review of Resident 1's Assessment dated 03/31/2023 showed Resident 1 had multiple major mental health diagnosis that led the resident to exhibit multiple behaviors. Assessment showed Resident 1 required the AFH to assist with problem solving, resolving disagreements, provide the resident with time and space when irritated, and to assist with managing obsessive/repetitive behaviors. Resident 1's Assessment showed the resident had issues with short-term memory which required the AFH to answer the residents' repetitive questions, provide them with information on the plans for the day, and write down a schedule. The Assessment showed Resident 1 was very selective with what they ate and enjoyed pork chops, peanut butter and jelly sandwiches, and meatloaf. In addition, Resident 1 was unwilling to eat vegetables and most fruits and required assistance in managing a balanced diet.

In an interview on 09/06/2024 at 11:56 AM, Staff A stated that they may have forgotten to write in behaviors and interventions on Resident 1's NCP.

In an exit interview on 09/06/2024 at 4:19 PM, Staff A stated that Resident 1 opened and closed their window so often that it had to be replaced.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date)_____.	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
_____	_____
Provider (or Representative)	Date

WAC 388-76-10380 Negotiated care plan Timing of reviews and revisions. The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:

(4) At least every twelve months.

This document was prepared by Residential Care Services for the Locator website.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to update the Negotiated Care Plan (NCP) for 1 of 2 sampled residents (Resident 1) at least every twelve months. This failure placed Resident 1 at risk of unmet care needs.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 1 lived in and received care from the AFH.

Review of Resident 1's NCP dated 01/26/2023 showed Resident 1 was admitted to the AFH on [REDACTED]/2022.

In an interview on 09/06/2024 at 11:32 AM, Staff A, Provider, stated that they reviewed residents NCP's every year. Staff A further stated that they had not updated Resident 1's NCP.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date) 10/24/24.

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

Margaret Igbekoyi
Provider (or Representative)

10/10/24
Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

- (3) The care and services in a manner and in an environment that:
 - (b) Actively supports the safety of each resident; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to provide the assessed care needs of 1 of 2 residents (Resident 2) that actively

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to update the Negotiated Care Plan (NCP) for 1 of 2 sampled residents (Resident 1) at least every twelve months. This failure placed Resident 1 at risk of unmet care needs.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 1 lived in and received care from the AFH.

Review of Resident 1's NCP dated 01/26/2023 showed Resident 1 was admitted to the AFH on [REDACTED]/2022.

In an interview on 09/06/2024 at 11:32 AM, Staff A, Provider, stated that they reviewed residents NCP's every year. Staff A further stated that they had not updated Resident 1's NCP.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date)_____.	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
_____ Provider (or Representative)	_____ Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

- (3) The care and services in a manner and in an environment that:
- (b) Actively supports the safety of each resident; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to provide the assessed care needs of 1 of 2 residents (Resident 2) that actively

supported the safety of the resident. This failure placed Resident 2 at significant risk of harm from a lack of required supervision.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 2 lived in and received care from the AFH.

In an initial interview on 09/06/2024 at 9:23 AM, Staff A, Provider, stated that Resident 2's behavior's included tearing paper and taking off their clothes.

Observation on 09/06/2024 at 10:05 AM showed Resident 2's bedroom contained only a bed.

In an interview on 09/06/2024 at 10:06 AM, Staff A stated that Resident 2's belongings had been removed from their bedroom due to their behaviors.

Review of Resident 2's Negotiated Care Plan (NCP) dated 07/10/2024 showed Resident 2 was admitted to the AFH on [REDACTED]/2013. Further review showed Resident 2's diagnosis of [REDACTED] ([REDACTED]) was not included in Resident 2's NCP. Resident 2 NCP further showed the resident had an increase in behaviors in the last few months. Staff were to redirect Resident 2 when behaviors occurred to, day, time, and place, offer support with room arrangement, give a gentle explanation that others needed to sleep, ensure the resident had clothes on, and offer warm milk at bedtime. Additionally, Resident 2's NCP showed the resident had tried prescribed medication for their behaviors and sleep without success.

Review of Resident 2's Assessment dated 03/01/2024 showed Resident 2 required a high level of protective supervision. Further review of Resident 2's Assessment showed 5 pages (page 7, 13, 19, 20, and 24) that documented Resident 2 required line of sight supervision day and night. In addition, Resident 2 Assessment showed they destroyed electrical cords and put things in electrical outlets, destroyed furniture and other items if left unsupervised, and was at a great health and safety risk if staff did not have eyes on the resident day and night. Resident 2's Assessment also showed they did not sleep at night, were up and out of their bedroom every hour, and during this time Resident 2 took things apart or played with electrical outlets and wires if not supervised the entire day/night. Resident 2 required an awake night staff that was the residents 1:1 (always remained with the resident) to keep them safe for the duration of the night.

Resident 2's Assessment further showed they required extensive support with the prevention of emotional outbursts, assaults or injuries to others, property destruction, stealing, self-injury, pica (ingestion of inedible substances) non-aggressive but inappropriate behavior and wandering. In addition, Resident 2 required extensive support with managing attention seeking behavior, uncooperative behavior,

agitated/overreactive behavior, and obsessive/repetitive behavior.

In an interview on 09/06/2024 at 4:00 PM, Staff A stated that there was not awake night staff in the AFH. Staff A further stated that staff checked on Resident 2 regularly as they were on a toileting schedule. In addition, Staff A stated that they had put in a request for funding for 1:1 staff for Resident 2 but it had not been approved. Staff A stated that Resident 2 did not require a 1:1 staff throughout night.

In a phone interview on 09/16/2024 at 11:33 AM, Staff C, Caregiver, stated that they lived and worked in the AFH. Staff C further stated that Resident 2 went to bed at 8:00 PM, they checked on Resident 2 at 10:00 PM, and then in the morning. Additionally, Staff C stated that they slept at night and there was no awake night staff in the AFH.

Review of email correspondence received by the department on 09/11/2024 at 3:34 PM from Department Case Manager (DCM), showed the AFH was receiving additional funds, \$39.00 per day, to pay for awake night 1:1 staff for Resident 2.

Review of email correspondence received by the department on 09/16/2024 at 3:24 PM from DCM, showed even though the AFH was not receiving funding for an overnight staff, the AFH was still responsible for having awake night staff for Resident 2 as it was the residents assessed need.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date) 10/30/24.

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

Margaret Igbekoyi
Provider (or Representative)

10/10/24
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.

agitated/overreactive behavior, and obsessive/repetitive behavior.

In an interview on 09/06/2024 at 4:00 PM, Staff A stated that there was not awake night staff in the AFH. Staff A further stated that staff checked on Resident 2 regularly as they were on a toileting schedule. In addition, Staff A stated that they had put in a request for funding for 1:1 staff for Resident 2 but it had not been approved. Staff A stated that Resident 2 did not require a 1:1 staff throughout night.

In a phone interview on 09/16/2024 at 11:33 AM, Staff C, Caregiver, stated that they lived and worked in the AFH. Staff C further stated that Resident 2 went to bed at 8:00 PM, they checked on Resident 2 at 10:00 PM, and then in the morning. Additionally, Staff C stated that they slept at night and there was no awake night staff in the AFH.

Review of email correspondence received by the department on 09/11/2024 at 3:34 PM from Department Case Manager (DCM), showed the AFH was receiving additional funds, \$39.00 per day, to pay for awake night 1:1 staff for Resident 2.

Review of email correspondence received by the department on 09/16/2024 at 3:24 PM from DCM, showed even though the AFH was not receiving funding for an overnight staff, the AFH was still responsible for having awake night staff for Resident 2 as it was the residents assessed need.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date)_____ .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
_____ Provider (or Representative)	_____ 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 ensure 1 of 2 sampled residents (Resident 2) received prescribed medication as ordered by their Primary Care Physician (PCP) and failed to keep 2 of 2 sampled residents' (Resident 1 and Resident 2) medication logs current. These failures placed Resident 2 at risk of reoccurring symptoms from not receiving prescribed medication as ordered and placed Resident 1 and Resident 2 at risk of medication errors.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 1 and Resident 2 lived in and received medication from the AFH.

Resident 1

Review of Resident 1's September 2024 pharmacy generated medication log showed they were prescribed,

-Loperamide 2 milligrams (mg), take 1 capsule by mouth three times daily as needed for diarrhea.

-Nicotine 4 mg chewing gum, 1 each in the mouth or throat as needed for smoking cessation.

- "Ondansetron HCL" 4 mg, take 1 tablet by mouth every 8 hours as needed for nausea.

-Polyethylene Glycol 3350, mix 1 capful (17 grams) in 8 ounces (oz) of liquid and drink by mouth once daily as needed for constipation.

-Acetaminophen 325 mg, take 2 tablets (650 mg) by mouth every 6 hours as needed for pain.

- "Albuterol HFA" 90 micrograms (mcg), inhale 2 puffs by mouth every 4 hours as needed for asthma.

-Cyclobenzaprine 5 mg, take 1 tablet by mouth at bedtime as needed for muscle spasms/pain.

Further review of Resident 1's September 2024 medication log showed D/C

[discontinued] written on the entry for Loperamide 2 mg, Nicotine 4 mg, "Ondansetron HCL" 4 mg, Polyethylene Glycol 3350, Acetaminophen 325 mg, "Albuterol HFA" 90 mcg, and Cyclobenzaprine 5 mg.

In an interview on 09/06/2024 at 1:26 PM, Staff A, Provider/Resident Manager stated that since Resident 1 moved into the AFH [REDACTED]/2022] they had continued to write D/C on the residents' medications they did not use. Staff A further stated that they had spoken to Resident 1's PCP in April 2024, to have the discontinued medications removed from Resident 1's medication log. Further, Staff A stated that they had contacted the pharmacy multiple times to have Resident 1's Loperamide 2 mg, Nicotine 4 mg, "Ondansetron HCL" 4 mg, Polyethylene Glycol 3350, Acetaminophen 325 mg, "Albuterol HFA" 90 mcg, and Cyclobenzaprine 5 mg removed from their medication log. Staff A stated that they had no discontinuation orders for Resident 1's Loperamide 2 mg, Nicotine 4 mg, "Ondansetron HCL" 4 mg, Polyethylene Glycol 3350, Acetaminophen 325 mg, "Albuterol HFA" 90 mcg, and Cyclobenzaprine 5 mg.

Resident 2

Review of Resident 2's September 2024 pharmacy-generated medication log showed Resident 2 was prescribed Triamcinolone 0.1 percent (%) cream, apply 0.5 grams (1 fingertip unit) to arms and legs twice daily for two weeks on, then take 1 week off. Further review showed the 8 PM dose from 09/01/2024-09/05/2024 had not been initialed.

In an interview on 09/06/2024 at 2:03 PM, Staff A stated that Resident 2's 8:00 PM dose of Triamcinolone 0.1% cream had been given 09/01/2024-09/05/2024. Staff A further stated that staff had initialed the wrong time below the entry for Triamcinolone 0.1% cream and then crossed out their initials. In addition, Staff A stated that if Resident 1 had a rash they used the Triamcinolone 0.1% cream as prescribed but if the resident did not have a rash, they did not use the medication.

Review of Resident 2's August 2024 pharmacy-generated medication log showed no initialed entries for Triamcinolone 0.1% cream, apply 0.5 grams (1 fingertip unit) to arms and legs twice daily for two weeks on, then take 1 week off.

In a phone interview on 09/17/2024 at 10:56 AM, Collateral Contact 2 (CC2) stated that there was nothing on the medication label for Resident 2's Triamcinolone 0.1% cream that indicated it could be used as needed. CC2 further stated they had received no order from Resident 2's PCP indicating that the order had changed.

This document was prepared by Residential Care Services for the Locator website.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date) 10/24/24.

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

Margaret IgbeKOYI
Provider (or Representative)

10/10/24
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 keep medication found in 1 of 2 sampled resident's (Resident 1) bedroom (Bedroom ■). This failure placed Resident 1 at risk of harm from possible medication interaction with medication prescribed by their Primary Care Physician (PCP) or misuse of the medication.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 1 lived in and received care from the AFH.

Observation on 09/06/2024 at 10:08 AM, showed a bottle of leg cramp medication and clear eyes cooling comfort eye drops on top of Resident 1's dresser in their bedroom. Further observation showed that the bottle of leg cramp medication had no expiration date. In a continuous observation, Staff A, Provider, told Resident 1 that they were not to have medication in their bedroom. Resident 1 became visibly upset and Staff A told the resident that their PCP needed to be informed of all medication the resident was taking.

In an interview on 09/06/2024 at 4:30 PM, Staff A stated that Resident 1 went to the store independently and had purchased the medication when they went to the store. In addition, Staff A stated that they could not ask Resident 1 to check their bag when they returned to the AFH. Staff A stated that they were unsure how they were to ensure Resident 1 did not purchase medication when they went out.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date)_____.

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

Provider (or Representative)

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 keep medication found in 1 of 2 sampled resident's (Resident 1) bedroom (Bedroom ■■■). This failure placed Resident 1 at risk of harm from possible medication interaction with medication prescribed by their Primary Care Physician (PCP) or misuse of the medication.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 1 lived in and received care from the AFH.

Observation on 09/06/2024 at 10:08 AM, showed a bottle of leg cramp medication and clear eyes cooling comfort eye drops on top of Resident 1's dresser in their bedroom. Further observation showed that the bottle of leg cramp medication had no expiration date. In a continuous observation, Staff A, Provider, told Resident 1 that they were not to have medication in their bedroom. Resident 1 became visibly upset and Staff A told the resident that their PCP needed to be informed of all medication the resident was taking.

In an interview on 09/06/2024 at 4:30 PM, Staff A stated that Resident 1 went to the store independently and had purchased the medication when they went to the store. In addition, Staff A stated that they could not ask Resident 1 to check their bag when they returned to the AFH. Staff A stated that they were unsure how they were to ensure Resident 1 did not purchase medication when they went out.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date) 10/15/24.

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

Margaret Igbekeyi
Provider (or Representative)

10/10/24
Date

WAC 388-76-10490 Medication disposal Written policy Required. The adult family home must have and implement a written policy addressing the disposal of unused or expired resident medications. Unused and expired medication must be disposed of in a safe manner for:

(1) Current residents living in the adult family home; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to follow their medication disposal policy for 1 of 2 sampled residents (Resident 1). This failure placed Resident 1 at risk of not receiving the full effect of the medication.

Findings included...

Review of the AFH's 09/06/2024 "Medication Disposal Policy" showed all expired medication would be returned to the pharmacy.

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 1 lived in and received medication assistance from the AFH.

Observation on 09/06/2024 at 1:26 PM showed Staff A, Provider provided department staff with Resident 1's medication. Observation further showed "Albuterol HFA", 90 micrograms (mcg) Inhaler, inhale 2 puffs by mouth every 4 hours as needed for asthma for Resident 1. In addition, the medication label showed Resident 1's "Albuterol HFA" 90 mcg Inhaler expired on 01/05/2024.

In an interview on 09/06/2024 at 1:40 PM, Staff A stated that Resident 1 refused to use their Albuterol inhaler. Staff A further stated that the medication disposal policy of the AFH was to return the medication to the pharmacy.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date)_____.

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

Provider (or Representative)

Date

WAC 388-76-10490 Medication disposal Written policy Required. The adult family home must have and implement a written policy addressing the disposal of unused or expired resident medications. Unused and expired medication must be disposed of in a safe manner for:

(1) Current residents living in the adult family home; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to follow their medication disposal policy for 1 of 2 sampled residents (Resident 1). This failure placed Resident 1 at risk of not receiving the full effect of the medication.

Findings included...

Review of the AFH's 09/06/2024 "Medication Disposal Policy" showed all expired medication would be returned to the pharmacy.

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 1 lived in and received medication assistance from the AFH.

Observation on 09/06/2024 at 1:26 PM showed Staff A, Provider provided department staff with Resident 1's medication. Observation further showed "Albuterol HFA", 90 micrograms (mcg) Inhaler, inhale 2 puffs by mouth every 4 hours as needed for asthma for Resident 1. In addition, the medication label showed Resident 1's "Albuterol HFA" 90 mcg Inhaler expired on 01/05/2024.

In an interview on 09/06/2024 at 1:40 PM, Staff A stated that Resident 1 refused to use their Albuterol inhaler. Staff A further stated that the medication disposal policy of the AFH was to return the medication to the pharmacy.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date) 10/18/24.

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

Margaret Igbe
Provider (or Representative)

10/10/24
Date

WAC 388-76-10685 Bedrooms. The adult family home must meet all of the following requirements:

(11) Provide each resident a call bell, or an alternative way of alerting staff in an emergency, that the resident can use, unless the bedroom of an AFH staff member is within hearing distance of the resident's bedroom and a staff member will be within hearing distance at all times.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure 1 of 2 residents (Resident 2) had a way of alerting staff in an emergency and always had a staff member within hearing distance, of Resident 2's bedroom. This failure placed Resident 2 at risk of serious harm in the event of an emergency.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 2 lived in and received care from the AFH.

Observation on 09/06/2024 at 10:04 AM showed Resident 2's bedroom (Bedroom ■) did not have a call bell or way to alert staff in an emergency.

In an interview on 09/06/2024 at 10:05 AM, Staff A, Provider, stated that Resident 2 was unable to use a call bell. Staff A further stated that Resident 2 would play with the call bell or break it.

Observation on 09/06/2024 at 10:20 AM showed Resident 2's bedroom was located on one side of the AFH, and the staff's bedroom (Bedroom ■) was located at the other end of the AFH and not within hearing distance of Resident 2's bedroom.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date)_____.

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

Provider (or Representative)

Date

WAC 388-76-10685 Bedrooms. The adult family home must meet all of the following requirements:

(11) Provide each resident a call bell, or an alternative way of alerting staff in an emergency, that the resident can use, unless the bedroom of an AFH staff member is within hearing distance of the resident's bedroom and a staff member will be within hearing distance at all times.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure 1 of 2 residents (Resident 2) had a way of alerting staff in an emergency and always had a staff member within hearing distance, of Resident 2's bedroom. This failure placed Resident 2 at risk of serious harm in the event of an emergency.

Findings included...

During a visit on 09/06/2024 at 8:40 AM, observation showed Resident 2 lived in and received care from the AFH.

Observation on 09/06/2024 at 10:04 AM showed Resident 2's bedroom (Bedroom ■) did not have a call bell or way to alert staff in an emergency.

In an interview on 09/06/2024 at 10:05 AM, Staff A, Provider, stated that Resident 2 was unable to use a call bell. Staff A further stated that Resident 2 would play with the call bell or break it.

Observation on 09/06/2024 at 10:20 AM showed Resident 2's bedroom was located on one side of the AFH, and the staff's bedroom (Bedroom ■) was located at the other end of the AFH and not within hearing distance of Resident 2's bedroom.

Statement of Deficiencies

License #: 750596

Compliance Determination # 46824

Plan of Correction

MAGGIES AFH

Completion Date

Page 14 of 14

Licensee: MARGARET IGBEKOYI

09/26/2024

Observation on 09/06/2024 at 11:09 AM showed Staff A placed a call bell on a green neck strap around Resident 2's neck. Further observation showed at 11:16 AM, Resident 2 had pushed the call bell twice since it had been provided. In addition, Staff A told Resident 2 not to push the call bell button.

In an interview on 09/06/2024 at 2:30 PM, Resident 2 stated that the call bell button on the green neck strap did not do anything.

Observation on 09/06/2024 at 2:31 PM showed Resident 2 pushed the call bell button several times, setting off the alert system.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date) 10/20/24.

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

Margaret Igbekoyi
Provider (or Representative)

10/10/24
Date

This document was prepared by Residential Care Services for the Locator website.

Observation on 09/06/2024 at 11:09 AM showed Staff A placed a call bell on a green neck strap around Resident 2's neck. Further observation showed at 11:16 AM, Resident 2 had pushed the call bell twice since it had been provided. In addition, Staff A told Resident 2 not to push the call bell button.

In an interview on 09/06/2024 at 2:30 PM, Resident 2 stated that the call bell button on the green neck strap did not do anything.

Observation on 09/06/2024 at 2:31 PM showed Resident 2 pushed the call bell button several times, setting off the alert system.

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, MAGGIES AFH is or will be in compliance with this law and / or regulation on (Date)_____.

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

Provider (or Representative)

Date