STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

KINDRED CARE SERVICES PLLC
VALLEY ROAD RESIDENTIAL CARE
3072 Valley Road NE
Moses Lake, WA 98837

RE: VALLEY ROAD RESIDENTIAL CARE License # 751743

Dear Provider:

This letter addresses Compliance Determination(s) 37900 (Completion Date 03/07/2024) and 35780 (Completion Date 02/02/2024).

The Department completed a follow-up inspection of your Adult Family Home on 03/07/2024 and found that you have corrected the violations listed in the Complaint report dated 02/02/2024. Your home is back in compliance as of 02/13/2024 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 388-76-10490-1, WAC 388-76-10475-3-a, WAC 388-76-10475-1

The Department staff who did the on-site verification:
Brittney Shull, Community Complaint Investigator

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, Field Manager
Region 1, Unit C
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: VALLEY ROAD RESIDENTIAL CARE
License/Cert.#: 751743
Compliance Determination #: 35780
Investigator: Brittney Shull
Investigation Date(s): 01/25/2024 through 02/02/2024
Complainant Contact Date(s):

Provider Type: Adult Family Home

Intake ID: 114600
Region/Unit #: RCS Region 1 / Unit C

Allegation(s):
The Adult Family Home (AFH) has been committing financial exploitation by ordering the named resident's narcotics after they had discharged to another facility.

Investigation Methods:

Sample:	Total residents: 6 Resident sample size: 4 Closed records sample size: 1
Observations:	Environment, Residents, Staff to resident interaction, Medication supply and availability.
Interviews:	Residents, Staff, Collateral Contacts.
Record Reviews:	Resident records, Negotiated Care Plan (NCP), Assessment, Medication Administration Record (MAR)/Log, Facility policy.

Investigation Summary:
Observations and interview showed that staff were responsive to resident needs. Staff to resident interactions were observed to be appropriate and respectful. Observations showed that medications were locked. It further showed that there was a supply of medications that had been discontinued or expired. Interview and record review showed that there was missing documentation in the mediation log. It further showed that that an outside health agency ordered a supply of medications for the named resident and it was sent to the AFH in error. Failed practice identified, WAC 388-76-10490 and WAC 388-76-10475, reference Statement of Deficiencies (SOD) dated 02/02/2024.

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 #: 751743	Compliance Determination #:35780
Plan of Correction	VALLEY ROAD RESIDENTIAL CARE	Completion Date
Page 1 of 5	Licensee: KINDRED CARE SERVICES PLLC	02/03/2024

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 01/25/2024 and 01/25/2024 of:

VALLEY ROAD RESIDENTIAL CARE
3072 Valley Road NE
Moses Lake, WA 98837

This document references the following complaint number(s): 114600

The following sample was selected for review during the unannounced on-site visit: 4 of 8 current residents and 1 former residents.

The department staff that investigated the Adult Family Home:

Brittney Shull, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit C
1200 Alder Street
Union Gap, WA 98903

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.

Michelle Cloaner
Residential Care Services

02/05/2024
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

1200 Alder Street, Union Gap, WA 98903

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Residential Care Services, Region 1 , Unit C
1200 Alder Street
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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) 02/13/2024 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 and record review, the Adult Family Home (AFH) failed to implement their policy for the disposal of unused or expired resident medications for 2 of 2 residents (Resident 1 and 2). This failure placed residents at risk for medication errors and misuse of unused or expired medications.

Findings included...

A record review of an undated facility document titled, "Disposal of Medications," showed that the disposal of medications was necessary when a medication has expired, has been discontinued by a health care practitioner, or when it is left behind when a resident moves out. It further showed that the pharmacy is unable to accept controlled substances (a prescription drug whose manufacture, possession or use is regulated by the government) for destruction, so two staff members should dispose of the controlled substance together. It lastly showed that all expired, outdated, or discontinued medications shall be removed from the facility within 30 days of discontinuation of use.

A record review of an undated facility document titled, "Exhibit 5: Resident Handbook," showed that all medications that are expired or no longer in use will be returned to the pharmacy or will be properly disposed of.

Resident 1

An observation on 01/25/2024 at 1:38PM, showed that the facility had an expired bubble pack of Tramadol (controlled substance and medication to relieve pain) 50 milligrams (mg) tablets containing 11 tablets for Resident 1. The prescription label on the bubble pack showed that it was filled on 07/21/2023 and expired on 01/07/2024. The prescription label order indicated that the medication may be used for up to 30 days.

A record review of Resident 1's Medication Administration Record dated 01/25/2024, showed that Resident 1 had an order for 50mg of Tramadol as needed. It further showed

Provider (or Representative) Date

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A record review of Resident 1's Medication Administration Record dated 01/25/2024, showed that Resident 1 had an order for 50mg of Tramadol as needed. It further showed

that Resident 1 received a dose of Tramadol on 01/03/2024 and 01/20/2024. It lastly showed that the medication was used 5 months after the order had been discontinued, and not disposed of.

Resident 2

A record review of a healthcare facility document titled, "After Visit Summary," dated 09/23/2023, showed that Resident 2 was ordered to stop taking oxycodone (controlled substance and medication to relieve pain) 5mg tablet.

A record review of Resident 2's Medication Administration Record dated 01/25/2024, showed that Resident 2 did not have an order for oxycodone.

An observation on 01/24/2024 at 5:09PM, showed that the facility had a bubble pack of oxycodone 5mg tablets containing 9 tablets for Resident 2 that had been discontinued on 09/23/2023. It further showed that the facility had not disposed of the medication, 4 months after the order had been discontinued.

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 ROAD RESIDENTIAL CARE is or will be in compliance with this law and / or regulation on (Date) 02/13/2024.

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

Provider (or Representative) — Date: 09/13/2024

WAC 388-76-10475 Medication Log. The adult family home must:

(1) Keep an up-to-date daily medication log for each resident except for residents assessed as medication independent with self-administration.

(3) Ensure the medication log includes:

(a) Initials of the staff who assisted or gave each resident medication(s);

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure the medication log was kept up to date with documentation of administered medication, including the initials of the staff who assisted or gave each medication for 4 of 4 residents (Resident 1, 2, 3, & 4). This failure placed residents at risk for medication errors.

that Resident 1 received a dose of Tramadol on 01/03/2024 and 01/20/2024. It lastly showed that the medication was used 5 months after the order had been discontinued, and not disposed of.

Resident 2

A record review of a healthcare facility document titled, “After Visit Summary,” dated 09/23/2023, showed that Resident 2 was ordered to stop taking oxycodone (controlled substance and medication to relieve pain) 5mg tablet.

A record review of Resident 2’s Medication Administration Record dated 01/25/2024, showed that Resident 2 did not have an order for oxycodone.

An observation on 01/24/2024 at 5:09PM, showed that the facility had a bubble pack of oxycodone 5mg tablets containing 9 tablets for Resident 2 that had been discontinued on 09/23/2023. It further showed that the facility had not disposed of the medication, 4 months after the order had been discontinued.

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_____ _____

Provider (or Representative) Date

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This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure the medication log was kept up to date with documentation of administered medication, including the initials of the staff who assisted or gave each medication for 4 of 4 residents (Resident 1, 2, 3, & 4). This failure placed residents at risk for medication errors.

Findings included...

A record review of an undated facility document titled, "Exhibit 5: Resident Handbook," showed that all regularly scheduled medications would be available and administered as ordered, and a record of all administered medications would be kept in the resident's file.

Resident 1

A record review of Resident 1's Negotiated Care Plan (NCP) dated 02/20/2023 showed that Resident 1 required assistance with medication administration, including set up and verbal cues to swallow.

A record review of Resident 1's "January 2024 Medication Administration Record (MAR)," dated 01/25/2024 showed that there was no documentation of whether a scheduled medication was administered for 162 occurrences.

Resident 2

A record review of Resident 2's NCP, dated 09/22/2023 showed that Resident 2 required medication assistance with set up.

A record review of Resident 2's "January 2024 MAR," dated 01/25/2024 showed that there was no documentation of whether a scheduled medication was administered for 57 occurrences.

Resident 3

A record review of Resident 3's NCP dated 11/28/2023 showed that Resident 1 required assistance with medication administration with set up.

A record review of Resident 3's "January 2024 MAR," dated 01/25/2024 showed that there was no documentation of whether a scheduled medication was administered for 60 occurrences.

Resident 4

A record review of Resident 3's NCP dated 10/06/2023 showed that Resident 1 required assistance with medication administration, including set up and putting the medications in

Findings included…

A record review of an undated facility document titled, “Exhibit 5: Resident Handbook,” showed that all regularly scheduled medications would be available and administered as ordered, and a record of all administered medications would be kept in the resident’s file.

Resident 1

A record review of Resident 1’s Negotiated Care Plan (NCP) dated 02/20/2023 showed that Resident 1 required assistance with medication administration, including set up and verbal cues to swallow.

A record review of Resident 1’s “January 2024 Medication Administration Record (MAR),” dated 01/25/2024 showed that there was no documentation of whether a scheduled medication was administered for 162 occurrences.

Resident 2

A record review of Resident 2’s NCP, dated 09/22/2023 showed that Resident 2 required medication assistance with set up.

A record review of Resident 2’s “January 2024 MAR,” dated 01/25/2024 showed that there was no documentation of whether a scheduled medication was administered for 57 occurrences.

Resident 3

A record review of Resident 3’s NCP dated 11/26/2023 showed that Resident 1 required assistance with medication administration with set up.

A record review of Resident 3’s “January 2024 MAR,” dated 01/25/2024 showed that there was no documentation of whether a scheduled medication was administered for 60 occurrences.

Resident 4

A record review of Resident 3’s NCP dated 10/06/2023 showed that Resident 1 required assistance with medication administration, including set up and putting the medications in

their mouth.

A record review of Resident 4's "January 2024 MAR," dated 01/25/2024 showed that there was no documentation of whether a scheduled medication was administered for 145 occurrences.

In an interview on 01/25/2024 at 3:03pm, Staff A, Provider, stated that the blanks in the Medication Administration Record for scheduled medications were likely from themselves forgetting to document. Staff A further stated that their practice was to first prepare the medications, then document afterwards by initialing the MAR and that is probably why there was no documentation for multiple medications for multiple residents.

Attestation Statement

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Provider (or Representative) — Date: 02/13/2024

their mouth.

A record review of Resident 4's "January 2024 MAR," dated 01/25/2024 showed that there was no documentation of whether a scheduled medication was administered for 145 occurrences.

In an interview on 01/25/2024 at 3:03pm, Staff A, Provider, stated that the blanks in the Medication Administration Record for scheduled medications were likely from themselves forgetting to document. Staff A further stated that their practice was to first prepare the medications, then document afterwards by initialing the MAR and that is probably why there was no documentation for multiple medications for multiple residents.

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