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

SOUNDVIEW ELDER CARE LLC

SOUNDVIEW ELDER CARE LLC
2324 SW 300TH ST
FEDERAL WAY, WA 98023

RE: SOUNDVIEW ELDER CARE LLC License # 751983

Dear Provider:

This letter addresses Compliance Determination(s) 45747 (Completion Date 08/15/2024) and 42369 (Completion Date 06/20/2024).

The Department completed a follow-up inspection of your Adult Family Home on 08/15/2024 and found that you have corrected the violations listed in the Full report dated 06/20/2024. Your home is back in compliance as of 06/24/2024 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 388-76-10430-1, WAC 388-76-10430-2-c, WAC 388-76-10430-2-d, WAC 388-76-10895-1, WAC 388-76-10895-1-a, WAC 388-76-10895-1-b, WAC 388-76-10895-2-b, WAC 388-76-10895-2-a

The Department staff who did the on-site verification:
Kirsten Biddle, AFH Licensor

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

Sincerely,

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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 06/06/2024, 06/06/2024 and 06/06/2024 of:

SOUNDVIEW ELDER CARE LLC
2324 SW 300TH ST
FEDERAL WAY, WA 98023

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:

Kirsten Biddle, AFH Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit E
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 — 06/21/2024 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.

Statement of Deficiencies	License #: 751983	Compliance Determination # 42369
Plan of Correction	SOUNDVIEW ELDER CARE LLC	Completion Date
Page 2 of 5	Licensee: SOUNDVIEW ELDER CARE LLC	06/20/2024

Sorina Bucur — Provider (or Representative)

June 27, 2024 — Date

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.

(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 observations, interviews, and record review, the Adult Family Home (AFH) failed to ensure 2 of 2 residents (Resident 1 and 2) received medications as ordered and accurately document the timing of medication provided on the medication administration record (MAR). This failure placed these residents at risk of medical and physical decline from not receiving medications as ordered.

Findings included...

Observation on 06/06/2024 at 11:52 AM showed Staff B, Caregiver, providing medication administration of a small, reddish-brown pill to Resident 1.
In an interview with Staff B at 11:54 AM, Staff B stated that the medication provided was Seroquel (a medication used to treat certain mental/mood disorders).

On 06/06/2024 at 3:15 PM, record reviews of Resident 1's MAR dated June 2024, showed under the column of date boxes on the MAR, the numerical date of "6" showed Staff B's initials in black ink indicating the following medications ordered for 8 PM administration were given: Atorvastatin (cholesterol lowering medication), Gabapentin (anti-seizure and nerve pain medication), Lisinopril (medication for high blood pressure), Melatonin (over the counter sleep aid), Metoprolol Tartrate (blood pressure medication), and Risperidone (mood disorder medication). Further review of the MAR did not show the medication Seroquel prescribed to Resident 1.

In an interview with Staff B on 06/06/2024 at 3:27 PM, they replied "oh" when Department Representative informed that Resident 1 did not have a prescription for Seroquel. When the question of what was administered to Resident 1 around lunch time or noon, Staff B stated that it was from the bubble pack (a type of packet in which small items are displayed and

Provider (or Representative) Date

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In an interview with Staff B on 06/06/2024 at 3:27 PM, they replied "oh" when Department Representative informed that Resident 1 did not have a prescription for Seroquel. When the question of what was administered to Resident 1 around lunch time or noon, Staff B stated that it was from the bubble pack (a type of packet in which small items are displayed and

sold, consisting of a transparent dome of plastic or similar material mounted on a firm backing such as cardboard).

Observation at 3:33 PM on 06/06/2024, of Resident 1's bubble pack revealed that the small, reddish-brown pill was Risperidone 0.5mg. The 8 PM dosage under "Bedtime" was not in the bubble pack.

Record review of Resident 2's MAR dated June 2024, showed there were three medications prescribed for administration at 8 PM. Staff B's initials were shown under the column of date boxes of "6" column as provided.

At 3:48 PM on 06/06/2024, the medication cabinet showed signage on the front cupboard door to read: "Six Rights of Drug Administration, Right person, Right drug, Right dose, Right time, Right route, Right documentation". Inside the locked medication cabinet, it was observed to have another signage posted in the middle of the shelves, "The Five "RIGHTS" of Medication Administration, The right patient, The right drug, The right dose, The right route, The right time". Additionally, two small plastic labeled cups with Resident 1 and Resident 2's names with the letters "PM" sat on separate shelves. Inside each of the cups were several colored pills. Resident 1's cup did not contain the small, reddish-brown pill (Risperidone) as prescribed for 8 PM dosage. Resident 2's cup contained the prescriptions of stool softener, Flomax (urinary retention medication), and Trazadone (medication for sleeping) – all prescribed for 8 PM.

In an interview with Staff B at 3:50 PM, the question was asked what the pre-poured medication in the cabinet is for. Staff B replied that they were for the evening medications for Resident 1 and 2. Confirming that the initials on the MAR's were Staff B's, they stated, "They are supposed to do after I give the medication". Staff D, Caregiver, then began to explain the behaviors of Resident 1 to warrant the use of the Risperidone and therefore this is why Staff B gave the 8 PM dosage. Further discussion requested that Staff D allow Staff B to describe what behaviors they were seeing to provide this medication earlier than prescribed. Staff B responded that the anxious behaviors were demonstrated when they were getting Resident 1 for lunch, having a hard time finding their words verbally and making repetitive statements.

Record review of Resident 1's MAR dated June 2024, showed on page three of four a prescription of Lorazepam (anti-anxiety) PRN (as needed) that did not have any initials recorded. Lorazepam was not given to Resident 1 during anxiety episodes as described by Staff B above.
In another interview with Staff B and Staff A, Provider, at 3:55 PM on 06/06/2024, the MAR and Lorazepam PRN order was discussed and shown, "as needed for anxiety". When the Department Representative inquired about not using the prescribed medication for the anxious behaviors Staff B described, there was no answer by Staff B as to why the Lorazepam was not given.

In an interview with Staff A on 06/10/2024 at 4:40 PM, they reported that the AFH's nurse delegator was scheduled to review the medication administration protocols and

prescriptions for both Resident 1 and 2.

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, SOUNDVIEW ELDER CARE LLC is or will be in compliance with this law and / or regulation on (Date) 06/24/2024

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

Tonia Buan — Provider (or Representative)

06/27/2024 — Date

WAC 388-76-10895 Emergency evacuation drills Frequency and participation.

(1) There are two types of emergency evacuation drills:

(a) A full evacuation is evacuation from the home to the designated safe location; and

(b) A partial evacuation is evacuation to the designated emergency exit.

(2) The adult family home must conduct:

(a) Partial emergency evacuation drills which occur during random staffing shifts at least every sixty days, with each resident participating in at least one each calendar year;

(b) A full emergency evacuation drill at least once each calendar year, with all residents participating in the drill together and at the same time; and

This requirement was not met as evidenced by:

Based on observations, interviews, and record review, the Adult Family Home (AFH) failed to perform partial and full emergency evacuation drills as required. This placed 2 of 2 residents (Resident 1 and 2) at risk of harm in the event of an emergency requiring evacuation.

Findings included...

An observation made on 06/06/2024 at 10:52 AM showed Resident 1 and 2, sitting in their wheelchair in the living room perpendicular to the front door and hallway, watching a movie. No other staff or people were observed in this room.

Review of record titled, "Negotiated Care Plan" for Resident 1 dated 02/20/2024, showed "Resident is NOT Physically and mentally capable of safely getting out of the home without the assistance of another individual or the use of mobility aids."

prescriptions for both Resident 1 and 2.

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Provider (or Representative) _____ Date _____

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(2) The adult family home must conduct:

(a) Partial emergency evacuation drills which occur during random staffing shifts at least every sixty days, with each resident participating in at least one each calendar year;

(b) A full emergency evacuation drill at least once each calendar year, with all residents participating in the drill together and at the same time; and

This requirement was not met as evidenced by:

Based on observations, interviews, and record review, the Adult Family Home (AFH) failed to perform partial and full emergency evacuation drills as required. This placed 2 of 2 residents (Resident 1 and 2) at risk of harm in the event of an emergency requiring evacuation.

Findings included...

An observation made on 06/06/2024 at 10:52 AM showed Resident 1 and 2, sitting in their wheelchair in the living room perpendicular to the front door and hallway, watching a movie. No other staff or people were observed in this room.

Review of record titled, “Negotiated Care Plan” for Resident 1 dated 02/20/2024, showed “Resident is NOT Physically and mentally capable of safely getting out of the home without the assistance of another individual or the use of mobility aids.”

Statement of Deficiencies	License #: 751983	Compliance Determination # 42369
Plan of Correction	SOUNDVIEW ELDER CARE LLC	Completion Date
Page 5 of 5	Licensee: SOUNDVIEW ELDER CARE LLC	06/20/2024

In an interview with Staff A, Provider, at 12:50 PM, they described the needs of Resident 2, a recently admitted resident, to require line of sight supervision as they are a fall risk or have had a history of falls at their prior placement and at the AFH. Staff A reported that the staff are to provide stand by assistance with line of sight except for while sleeping and extensive assistance with feeding.

Record review of the binder with fire drill logs showed the last full evacuation took place on 05/22/2023, while the last partial evacuation was 07/21/2023.
The fire drill log binder did not show any completed for 2024.

In an interview with Staff A, on 06/06/2024 at 2:04 PM, they were asked to locate the current logs and confirmed it would be in the binder, however they could not find any 2024 logs. At 2:10 PM, Staff A stated, "I don't know how... I'm surprised".

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, SOUNDVIEW ELDER CARE LLC is or will be in compliance with this law and / or regulation on (Date) 06/15/2024

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

Tovina Brown — Provider (or Representative)

06/27/2024 — Date

In an interview with Staff A, Provider, at 12:50 PM, they described the needs of Resident 2, a recently admitted resident, to require line of sight supervision as they are a fall risk or have had a history of falls at their prior placement and at the AFH. Staff A reported that the staff are to provide stand by assistance with line of sight except for while sleeping and extensive assistance with feeding.

Record review of the binder with fire drill logs showed the last full evacuation took place on 05/22/2023, while the last partial evacuation was 07/21/2023.
The fire drill log binder did not show any completed for 2024.

In an interview with Staff A, on 06/06/2024 at 2:04 PM, they were asked to locate the current logs and confirmed it would be in the binder, however they could not find any 2024 logs. At 2:10 PM, Staff A stated, “I don’t know how… I’m surprised”.

Attestation Statement

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

Provider (or Representative) _____ Date _____

SOUNDVIEW ELDER CARE, LLC AFH

PLAN OF CORRECTION

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.

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

(a) Assessment indicates the amount of medication assistance needed by the resident;

(b) Negotiated care plan identifies the medication service that will be provided to the resident;

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

(d) Receives medications as required.

Sound View AFH plan of correction for medication system:

1. Nurse delegator was contacted and notified of inspection report. Nurse came to AFH and reviewed the medications and the competency of the staff regarding medication administration. Review of medication administration was done as well as re-education to all staff regarding the 5 rights of medication administration including documentation, time of administration, medication interactions, side effects, use of PRNs, when to contact pharmacist and doctor.
2. Nurse delegator came to the final decision that staff B is to be rescind from delegation for medication administration due to inability to verbalize medication deficiency made on 6/6/24 and corrective actions to be taken.
3. Delegated staff is in place for medication administration using the rights of medication administration in order to ensure patient safety.
4. Steps taken for medication administration. Prior to medication administration, delegated staff is to review medication order with MAR and with medicine packaging to review that all state the correct *patient name, medication, dosage, route of administration, timing of administration*. PRN medications are to state indication for giving. For safety, *one patient medication preparation and administration at a time*, and avoid interruptions as to not make medication error. Caregiver is to set up patient sitting in proper position for medication administration, and notify patient of medication administration (and if placed in foods). Caregiver to ensure proper hand hygiene prior and post medication administration. Verify name with patient, MAR and medication box. *Medications are to be administered as ordered, in a timely manner per WAC 388-76-10470.* Document medication administration on MAR right after ordered medication was administered. If patient refuses medication, circle initials and write reason for refusal on back of MAR. Notify doctor if continues refusal. Caregiver to observe for medication side effects and to notify delegator and doctor accordingly in order to ensure patient safety.
5. Medication administration system will be reviewed and supervised routinely by nurse delegator.

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, Soundview Elder Care, LLC is or will be in compliance with this law and / or regulation on (Date) 06/24/24 In addition, I will implement a system to monitor and ensure contivbmnued compliance with this cited deficiency.

Sonia Bueno 06/27/2024

Provider (or Representative) Date

WAC 388-76-10895

Emergency evacuation drills—Frequency and participation.

(1) There are two types of emergency evacuation drills:

(a) A full evacuation is evacuation from the home to the designated safe location; and

(b) A partial evacuation is evacuation to the designated emergency exit.

(2) The adult family home must conduct:

(a) Partial emergency evacuation drills which occur during random staffing shifts at least every sixty days, with each resident participating in at least one each calendar year;

(b) A full emergency evacuation drill at least once each calendar year, with all residents participating in the drill together and at the same time.

Sound View AFH plan of correction for evacuation drills:

1. The adult family home will perform evacuation drills per WAC 388-76-10895.
    a. All working staff is educated and instructed regarding emergency evacuation for each resident, and the designated meeting point for the AFH. Staff is educated on the level of assistance for each resident, which is also written in the patient assessment and care plan. This is part of safety and orientation for staff.
    b. Since 2002 consistently we perform full evacuation every 60 days or sooner. We misplaced the evacuation folder when we painted the office which resulted in non documentation of evacuation. To ensure we document accordingly every 60 days, we set reminders in physical and mobile calendars.
    c. Shift staff will perform emergency evacuations, full yearly and partial evacuation from the AFH to the designated emergency exit every 60 days.

If resident refuses to participate in emergency evacuation, we respect their right to refuse and we comply by doing a mock evacuation using a pillow and an estimate of time that it will take with their level of assistance.

d. The AFH has a designated emergency evacuation folder where we document the name of resident and staff included in the drill, the date and time, partial or full evacuation, as well as the length of time it took to complete full evacuation, ensuring that the time is less than 5 minutes.

Answer to the findings included (page 9 of 11) :

- Both our residents are total assist and dependent on caregivers for ambulatory needs, and their Negotiated Care Plan and Assessments show their need of assistance, being dependent on caregiver intervention and mobility aids, in case of evacuation. All our staff know that.

- Regarding the finding of Residents 1 and 2, being seen in the living room being seen watching TV, they were supervised by Staff D all the time while they were there. Staff D was probably not seen by the licensor, but he was seated in the chair with view to the big window, behind the wheelchair of Staff 1 but with constant sight over the 2 residents.
From the little room where the licensor was interviewing Staff B, it is not a good angle to observe Staff D seated behind Resident 1.
We do not have a standing doctor order to provide stand by assistance continuously.
It is our main goal to provide safety and comfort to our residents and we do our best for that.

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Provider (or Representative) Date