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

R DEOL LLC
THE LOVING ONES ADULT FAMILY HOME II
2315 S 254TH COURT
DES MOINES, WA 98198

RE: THE LOVING ONES ADULT FAMILY HOME II License # 752109

Dear Provider:

This letter addresses Compliance Determination(s) 59825 (Completion Date 05/19/2025) and 57670 (Completion Date 04/08/2025).

The Department completed a follow-up inspection of your Adult Family Home on 05/19/2025 and found that you have corrected the violations listed in the Follow up report dated 04/08/2025. Your home is back in compliance as of 04/08/2025 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 388-76-10400-3-c, WAC 388-76-10400-3-b

The Department staff who did the on-site verification:
Michele Grumke, AFH Licensor

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

Sincerely,

Lydia Owusu-Acheampong, Community Field Manager
Region 2, Unit G
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 an unannounced on-site follow-up on 04/08/2025 of:
THE LOVING ONES ADULT FAMILY HOME II
2309 S 254TH COURT
DES MOINES, WA 98198

This document references the following SOD dated: 04/08/2025

The following sample was selected for review during the unannounced on-site visit: 2 of 4 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Michele Grumke, 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 — 04/14/2025 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) — 4/18/25 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

(c) Reasonably accommodates each resident's individual needs and preferences except when the accommodation endangers the health or safety of the individual or another resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure the care and services for 1 of 2 sampled resident's (Resident 2) were provided in a safe manner that did not endanger the resident's health or safety. This failure placed Resident 2 at risk of serious health complications.

Findings included...

During a follow up visit on 04/08/2025 at 9:42 AM, observation showed Resident 2 lived in and received medication assistance from the AFH.

A review of Resident 2's March 2025 pharmacy generated Medication Administration Record (MAR) showed Resident 2 was prescribed, Metoprolol Succinate 50 milligrams (mg), take 1 tablet by mouth twice daily for Hypertension (HTN), high blood pressure, hold for Systolic Blood Pressure [(SBP), measures the pressure of the blood vessel walls when the heart beats] is less than 100 and Heart Rate (HR) is less than 60.

A review of Resident 2's Blood Pressure Log dated March 2025 showed on 03/15/2025 at 10:00 AM Resident 2's HR was 52.

A further review of Resident 2's March 2025 pharmacy generated MAR showed, Resident 2's Metoprolol Succinate 50 mg had been initialed as given on 03/15/2025 when the HR read was 52.

In an interview on 04/08/2025 at 10:21 AM, Staff C, Caregiver, stated that initialed entries on resident MARs indicate that medication had been given. Staff C further stated that if Resident 2's Metoprolol Succinate 50 mg had not been given, it would have been documented on Resident 2's MAR. Additionally, Staff C stated that there was no documentation on Resident 2's MAR that Metoprolol Succinate 50 mg had been held on 03/15/2025.

This is an uncorrected deficiency previously cited on 02/27/2025 for subsection (3)(b).

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, THE LOVING ONES ADULT FAMILY HOME II is or will be in compliance with this law and / or regulation on (Date) 4/8/25.

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

Provider (or Representative) — Date: 4/18/25

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 02/13/2025 of:
THE LOVING ONES ADULT FAMILY HOME II
2309 S 254TH COURT
DES MOINES, WA 98198

The following sample was selected for review during the unannounced on-site visit: 2 of 4 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Michele Grumke, 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.

Dahl Kim
Residential Care Services

03/04/2025
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)

3/7/2025
Date

WAC 388-76-10166 Background checks Household members, noncaregiving and unpaid staff Unsupervised access.

(1) The adult family home must not allow individuals specified in WAC 388-76-10161 (3) to have unsupervised access to residents until the home receives results of the Washington state name and date of birth background check from the department.

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 1 household members (HH1) had a Washington state name and date of birth background inquiry (BGI) result prior to allowing unsupervised access to the residents. This failure placed all residents (Residents 1, 2, 3, and 4) at risk of harm from a household member with an unknown criminal background.

Findings included...

During a visit on 02/13/2025 at 8:25 AM, observation showed Residents 1, 2, 3, and 4 lived in and received care from the AFH. Further observation showed a staircase near the entryway inside the AFH with a closed door at the top of the stairs.

In an interview on 02/13/2025 at 9:10 AM, Staff C, Designee/Caregiver, stated that HH1 was a renter that lived on the second floor of the AFH.

During a review of administrative records, Staff C provided department staff with a copy of HH1's BGI. Review showed that HH1's BGI had been completed on 02/13/2025, the same day as the visit.

In an interview on 02/13/2025 during the exit at 5:12 PM, Staff C stated that HH1 had lived upstairs in the AFH for over a month.

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, THE LOVING ONES ADULT FAMILY HOME II is or will be in compliance with this law and / or regulation on (Date) 3/7/25 .

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

Provider (or Representative) 3/7/25 Date

WAC 388-76-10195 Adult family home Staff Generally. The adult family home must ensure:

(1) When one or more residents are in the home, enough staff are available in the home to meet the needs of each resident, except as provided in WAC 388-76-10200 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure staff were available in the AFH to meet the resident's needs. This failure placed all residents (Residents 1, 2, 3, and 4) at serious risk of harm or injury in the event of an emergency requiring evacuation from the home occurred or if a resident had a medical emergency.

Findings included...

During a visit on 02/13/2025 at 8:25 AM, observation showed Residents 1, 2, 3, and 4 lived in and received care from the AFH.

Observation on 02/13/2025 at 8:27 AM showed Resident 1 was seated in a recliner in the family room watching TV. Further observation showed a wheelchair in the living room. In addition, observation of Resident 1's bedroom showed a [redacted], used to safely transfer residents.

Observation on 02/13/2025 at 8:28 AM showed Resident 2 was sleeping in bed and used a [redacted] ([redacted]) [redacted], helps with breathing. Further observation showed Resident 2 had a wheelchair and [redacted] in their bedroom.

Observation on 02/13/2025 at 8:29 AM showed Resident 3 was sitting in bed eating breakfast. Further observation showed a walker in Resident 3's bedroom.

Observation on 02/13/2025 at 8:30 AM showed Resident 4 was seated in a chair in their bedroom. Further observation showed a walker in Resident 4's bedroom.

In an interview on 02/13/2025 at 8:52 AM, Staff C, Designee/Caregiver, stated that Residents 1, 2, 3, and 4 all required assistance with evacuation from the AFH.

In an interview on 02/13/2025 at 9:10 AM, Staff C stated that there were 3 other AFH's owned and operated by Staff A, Entity Representative, within walking distance. Staff C further stated that they would be in and out of the AFH during the inspection as a need to go to other homes arose.

Observation on 02/13/2025 at 11:15 AM showed, Staff C and Staff D, Caregiver, had left and returned to the AFH several times during the inspection leaving Staff E, Caregiver, as the only staff in the AFH.

Observation on 02/13/2025 at 11:16 AM showed, Department Staff (DS) asked Staff E if Staff D was available. Staff E stated that they would call Staff D as they were currently not in the AFH nor was Staff C. Observation further showed Staff E left the AFH and there were no staff available to assist the residents.

Observation on 02/13/2025 at 11:18 AM showed Staff C arrived at the AFH.

Observation on 02/13/2025 at 11:19 AM showed Staff E and Staff D arrived at the AFH.

In an interview on 02/13/2025 at 11:20 AM, Staff E stated that they had been nervous due to the inspection and that it would never happen again [leaving residents without staff].

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, THE LOVING ONES ADULT FAMILY HOME II is or will be in compliance with this law and / or regulation on (Date) 3/7/25 .

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

Provider (or Representative) — Date: 3/7/25

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 2 sampled staff (Staff E, Caregiver) had an initial Tuberculosis (TB) skin test completed within 3 days of employment and a second test completed one to three weeks after the first. This failure placed all residents (Residents 1, 2, 3, and 4) and 2 of 2 staff (Staff C, Designee/Caregiver, and Staff D, Caregiver) who worked in the AFH at risk of exposure to TB, a communicable disease that affects the lungs.

Findings included...

During a visit on 02/13/2025 at 8:25 AM, observation showed Residents 1, 2, 3, and 4 lived in and received care from the AFH. Further observation showed Staff C, Staff D, and Staff E worked in the AFH.

A review of Staff E's personnel file showed a hire date of 11/08/2024. Further review showed a negative TB skin test dated 11/27/2024.

In an interview on 02/13/2025 at 1:08 PM, Staff C stated that Staff E had completed only 1 TB skin test. Staff C further stated that they had called the medical facility Staff E had the skin test completed, asked if Staff E required a second skin test, and was told no. Staff C stated that they did not know why Staff E's TB skin test was completed late.

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, THE LOVING ONES ADULT FAMILY HOME II is or will be in compliance with this law and / or regulation on (Date) 3/7/25 .

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

Provider (or Representative) — Date: 3/7/25

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:

(b) Reduce tension, agitation and problem behaviors;

(c) Respond to resident's special needs, including, but not limited to medical devices and related safety plans;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to include in 1 of 2 sampled resident (Resident 2) Negotiated Care Plan (NCP) the medical devices used by the resident, how they were used, when they were used, as well as any assistance staff were required to provide. In addition, the AFH failed to include in 1 of 1 resident (Resident 4) a plan to ensure Resident 4 did not have access to toxic substances and that they remained in locked storage. The AFH also failed to ensure Resident 4's NCP included the resident's problem behaviors, staff interventions, and the symptoms the resident's psychopharmacological (used to treat mental health conditions/symptoms) medication addressed. These failures placed Resident 2 and Resident 4 at risk of unmet care needs.

Findings included...

During a visit on 02/13/2025 at 8:25 AM, observation showed Resident 2 and Resident 4 lived in and received care from the AFH.

Resident 2
Observation on 02/13/2025 at 8:28 AM showed Resident 2 was sleeping in bed and used a [redacted] ([redacted]) [redacted], helps with breathing.

Observation on 02/13/2025 at 11:00 AM of Bedroom [redacted], used by Resident 2 showed [redacted], for people with low blood oxygen levels, with [redacted] attached. Further observation showed Resident 2 had a [redacted] in their bedroom.

A review of Resident 2's NCP dated 05/10/2024 showed Resident 2 was admitted to the AFH on [redacted]/2022. Resident 2's NCP indicated the resident did not use [redacted]. In addition, there was no documentation in Resident 2's NCP that they used a [redacted] or [redacted]. The NCP for Resident 2's showed the resident required a [redacted], to safely transfer individuals, except the NCP did not indicate the number of staff required for transfers.

In a follow up phone interview on 02/21/2025 at 12:25 PM, Staff C, Designee/Caregiver, stated that they did not know if Resident 2 used the [redacted] or not.

Resident 4
Observation on 02/13/2025 at 10:40 AM showed Resident 4 was seated in a chair in their bedroom applying nail polish to their fingernails. Further observation showed Resident 4 was alone in their bedroom and had no staff supervision.

In an interview on 02/13/2025 at 10:41 AM, Department Staff (DS) asked Staff C if Resident 4 had been assessed to use the nail polish unsupervised. Staff C stated that Resident 4 had not. DS informed Staff C that Resident 4's nail polish was required to be kept in locked storage as it was a toxic substance. Staff C stated that they could not do that as Resident 4 would call the police.

A review of Resident 4's NCP date 09/15/2024 showed Resident 4 was admitted to the AFH on [redacted]/2023. Further review showed Resident 4's NCP did not indicate that the resident had been assessed to use toxic substances unsupervised.

Observation on 02/13/2025 at 3:20 PM showed from Resident 4's bedroom loud coughing and sounds of gasping for air. Further observation showed Staff D, Caregiver, responded and asked Resident 4 what was wrong, were they having trouble breathing or were they choking. Observation showed Resident 4 did not nod or verbally respond when either question was asked, the resident pointed to their throat and continued to cough as well as gasp for air. In addition, observation showed Staff D provided Resident 4 with their Albuterol Inhaler (used to treat shortness of breath) and the resident continued to cough and gasp for air. Further observation showed Staff D performed the Heimlich maneuver (a first aid technique used to treat choking) and the resident continued to cough and gasp for air.

Observation on 02/13/2025 at 3:30 PM showed Staff D called emergency services.

Observation on 02/13/2025 at 3:40 PM showed an Emergency Medical Technician (EMT) asked Resident 4 a series of questions concerning their symptoms. Observation further showed the EMT stated it wasn't clear what was happening with Resident 4. In addition, observation showed the EMT informed Staff D that Resident 4 would be taken to a Local Health Facility (LHF) due to their medical history and current symptoms.

In an interview on 02/13/2025 during the exit at 5:12 PM, Staff C stated that Resident 4 liked to go to LHF's. Staff C further stated that Resident 4's Representative had stated not to send the resident to the LHF in an ambulance as they could no longer afford it. In addition, Staff C stated that Resident 4 had once presented with symptoms of a stroke, except it turned out to be behavioral not medical. Staff C stated that when there were visitors to the AFH Resident 4 had behaviors. Staff C further stated that if they were in the AFH Resident 4 would not have acted that way [coughing and gasping for air].

In an interview on 02/13/2025 at 5:43 PM, Staff D stated that they had never worked in the AFH when Resident 4 acted like that.

A review of Resident 4's NCP dated 09/15/2024 showed Resident 4 was admitted to the AFH on [redacted]/2023. Further review showed Resident 4's NCP indicated the resident had specialty needs except the NCP did not include what they were. In addition, review showed Resident 4's NCP did not indicate that the resident had a history of frequent LHF visits or that the resident had behavioral issues when there were visitors in the AFH. Review showed Resident 4's NCP did not contain any interventions for staff to decrease or prevent the behaviors. Continued review of Resident 4's NCP showed that the resident took psychopharmacological medication, Quetiapine (an antipsychotic used to treat significant mental health symptoms) and Escitalopram (used to treat depressive symptoms). Resident 4's NCP showed no symptoms listed that each medication was prescribed to treat

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, THE LOVING ONES ADULT FAMILY HOME II is or will be in compliance with this law and / or regulation on (Date) 3/7/25 .

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

Provider (or Representative) — Date: 3/7/25

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

(c) Reasonably accommodates each resident's individual needs and preferences except when the accommodation endangers the health or safety of the individual or another resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure the care and services for 2 of 2 sampled residents (Resident 2 and Resident 3) were provided in a safe manner and that resident preferences for 1 of 1 sampled resident (Resident 2) did not endanger the resident's health or safety. These failures placed Resident 2 and Resident 3 at risk of serious health complications and worsening of conditions

Findings included...

During a visit on 02/13/2025 at 8:25 AM, observation showed Resident 2 and Resident 3 received medication assistance from the AFH.

Resident 2
A review of Resident 2's January 2025 & February 2025 pharmacy generated Medication Administration Record (MAR) showed Resident 2 was prescribed,
-Metoprolol Succinate 50 milligrams (mg), take 1 tablet by mouth twice daily for Hypertension (HTN), high blood pressure, hold for Systolic Blood Pressure (SBP), measures the pressure of the blood vessel walls when the heart beats, less than 100 or Heart Rate (HR) less than 60. Review further showed all entries on Resident 2's MAR from 01/01/2025-02/12/2025 had initialed entries for the 8:00 AM and 4:00 PM dose.

- "Hydralazine HCL" 50 mg, take 1 tablet (50 mg) by mouth every evening hold for SBP less than 100. Further review showed all entries from 01/01/2025-02/12/2025 had initialed entries for the 4:00 PM dose.

Blood Pressure
A review of Resident 2's Blood Pressure (BP) Log documented from 01/06/2025-02/12/2025 showed one set of BP and HR records for each day and Resident 2's Metoprolol Succinate 50 mg was prescribed for twice daily 8:00 AM and 4:00 PM. Further review of Resident 2's BP Log showed no BP entry had a time that coincided with Resident 2's 4:00 PM dose of Metoprolol Succinate 50 mg and "Hydralazine HCL" 50 mg. Additional review of Resident 2's BP Log showed the following BPs were taken after the window of one hour before or one hour after medication can be given, for the 8:00 AM dose of Resident 2's Metoprolol Succinate 50 mg,

01/13/2025	12:00 PM
01/14/2025	10:00 AM
01/15/2025	9:45 AM
01/16/2025	10:00 AM
01/19/2025	10:00 AM
01/22/2025	10:00 AM
01/29/2025	10:00 AM
01/30/2025	11:00 AM
02/02/2025	10:00 AM
02/03/2025	10:00 AM
02/08/2025	10:00 AM
02/09/2025	10:00 AM

In an interview on 02/13/2025 at 1:37 PM, Staff D stated that they took Resident 2's BP twice daily, but did not write it down.

In a follow up phone interview on 02/18/2025 at 9:06 AM, Staff D stated that occasionally, mistakes had been made, and Resident 2 had been provided their medication late. Staff D further stated that Resident 2 preferred to sleep late. In addition, Staff D stated that they had spoken with Resident 2 and explained that if they want to take their medication later, the AFH would need to get an order from Resident 2's Primary Care Physician (PCP). Staff D stated that they had learned from Department Staff (DS) that to provide resident medication late, the AFH required a doctor's order.

HR
A further review of Resident 2's BP Log showed the following dates the HR was within the parameters to hold Resident 2's Metoprolol Succinate 50 mg, HR was less than 60,

01/06/2025	55
01/09/2025	58

01/10/2025 59
01/12/2025 57
01/16/2025 52
01/21/2025 56
01/23/2025 55
01/24/2025 57
01/25/2025 55
01/26/2025 57
01/27/2025 55
01/28/2025 56
02/11/2025 57
02/12/2025 57

In an interview on 02/13/2025 at 1:37 PM, Staff D stated that if one of Resident 2's BP medications were held, it was documented on the residents MAR. In addition, Staff D stated that they had previously held Resident 2's BP medication but would need to review Resident 2's MAR to determine which dates.

A review of Resident 2's January 2025 and February 2025 pharmacy generated MAR showed no documentation on the back indicating either medication had been held.

In a follow up phone interview on 02/18/2025 at 9:06 AM, Staff D stated that they provided Resident 2 their medication based on the resident's MAR. Staff D further stated that in the past mistakes were made not holding Resident 2's BP medication based on the residents HR. In addition, Staff D stated that they had begun to include Resident 2's HR in determining if Resident 2's BP medication should be held.

Resident 3
Observation on 02/13/2025 at 11:14 AM showed Staff E, Caregiver, had begun to prepare Resident 3's medication.

In an interview on 02/13/2025 at 11:15 AM, Staff E stated that they were preparing Resident 3's 8:00 AM medications as they had not been given.

In an interview on 02/13/2025 at 11:20 AM, Staff D stated that the reason Resident 3's medication was late was due to the inspection of the AFH. Staff D stated that they had been assisting DS. DS stated that upon entry, there were 3 staff working with 4 residents. DS asked if there was an order from Resident 3's PCP to provide the residents scheduled 8:00 AM medication at 11:15 AM. Staff D stated that there was no order and would call Resident 3's PCP.

Observation on 02/13/2025 at 11:23 AM showed, Staff C, Designee/Caregiver, called Resident 3's Representative for the phone number for the residents PCP. Resident 3's Representative stated that the phone number they had was a general number and not a direct line to Resident 3's PCP. Further observation showed Staff C ended the call and

stated, "I don't know what to do."

In an interview on 02/13/2025 at 11:26 AM, DS asked Staff C what the policy of the AFH was to provide medication to a resident late. Staff C stated that they didn't have one, that a similar situation had never occurred. DS asked Staff C if there was someone else, they could call to determine if it was safe to provide Resident 3 their 8:00 AM medication at 11:15 AM. Staff C did not respond and DS suggested to call the pharmacy.

Observation on 02/13/2025 at 11:28 AM showed, Staff C called Resident 3's pharmacy and explained the situation with Resident 3's late medication. Staff C was told that morning medications that were prescribed for once a day, could be given but any morning medications that were prescribed for twice a day, the morning dose should not be given.

Observation on 02/13/2025 at 11:40 AM showed, Staff E reviewed Resident 3's February 2025 pharmacy generated MAR. Further observation showed each medication entry had a photo and description of each medication. Additional observation showed Staff E removed the 2 medications from Resident 3's medication cup that were to be given twice daily.

A review of Resident 3's February 2025 pharmacy generated MAR showed Resident 3 was prescribed the following morning medications that were to be given twice daily:
- Levetiracetam 500 mg, Week 3-4: take 1 tablet every morning and 2 tables (1000 mg) once daily at bedtime and then start 1000 mg twice daily dosing.
-Divalproex Sodium 250 mg, Week 3-4, take 1 tablet by mouth twice daily.

Levetiracetam
A review of Resident 3's January 2025 and February 2025 pharmacy generated MAR showed Resident 3 was prescribed,
-Levetiracetam 500 mg, Week 1-2: take 1 tablet by mouth twice daily. Further review showed initialed entries from 01/28/2025-02/12/2025 for the 8:00 AM and 8:00 PM dose.

Observation of Resident 3's medication storage container showed a bubble pack of Levetiracetam 500 mg, Week 1-2: take 1 tablet by mouth twice daily, with 1 individual pill in 2 different packets.

In an interview on 02/13/2025 at 2:10 PM, Staff D stated that Resident 3 had been prescribed Levetiracetam 500 mg for seizures and required the medication to be titrated, started at a low dose and slowly increase the dose over days, weeks or months. Staff D further stated that Resident 3's Levetiracetam 500 mg, Week 1-2. should have been gone since it was over 14 days.

A review of Resident 3's February 2025 pharmacy generated MAR showed Resident 3

was prescribed,
-Levetiracetam 500 mg, Week 3-4: take 1 tablet every morning and 2 tablets (1000 mg) once daily and bedtime and then start 1000 mg twice daily dosing. Further review showed initialed entries for the 8:00 AM dose and 8:00 PM dose on 02/01/2025 and the 8:00 AM dose on 02/02/2025.
-Levetiracetam 1000 mg, Week 5: take 1 tablet by mouth twice daily. Further review showed 8:00 AM, 12:00 PM, and 8:00 PM were times listed on the MAR, the medication was prescribed for twice daily. In addition, review showed initialed entries for the 8:00 AM dose, 12:00 PM dose, and 8:00 PM dose on 02/01/2025 and the 8:00 AM dose on 02/02/2025.

In an interview on 02/13/2025 2:05 PM, Staff D stated that they had made a mistake when they initialed Resident 3's Levetiracetam 500 mg, Week 3-4 and Levetiracetam 1000 mg Week 5.

Divalproex Sodium
A further review of Resident 3's January 2025 and February 2025 pharmacy generated MAR showed Resident 3 was prescribed,
-Divalproex Sodium 250 mg, Week 1-2, take 1 tablet in the morning and 2 tablets (500 mg) once daily at bedtime. Further review showed initialed entries from 01/28/2025-02/12/2025 for the 8:00 AM and 8:00 PM dose. In addition, entries should have been initialed until 02/10/2025 as that was 14 days or 2 weeks of medication.
- Divalproex Sodium 250 mg, Week 3-4, take 1 tablet by mouth twice daily. Further review showed initialed entries for the 8:00 AM and 8:00 PM dose for 02/01/2025-02/12/2025.
- Divalproex Sodium 250 mg, Week 5-6, take 1 tablet at bedtime and then discontinue on week 7. Further review showed initialed entries from 02/01/2025-02/12/2025.
-Divalproex Sodium 250 mg, take 1 capsule by mouth every morning. Further review showed initialed entries for the 8:00 AM dose from 02/01/2025-02/12/2025. In addition, review showed a handwritten note "Duplicate See New Order."
-Divalproex Sodium 250 mg, take 2 tablets by mouth once daily at bedtime. Further review showed initialed entries for the 8:00 PM dose from 02/01/2025-02/12/2025. In addition, review showed a handwritten note "See New Orders."

In an interview on 02/13/2025 at 2:06 PM, Staff D stated that they had made a mistake when they initialed Resident 3's Divalproex Sodium 250 mg Week 3-4 and Week 5-6. Staff D further stated that Resident 3's Divalproex Sodium 250 mg, take 1 capsule by mouth every morning and take 2 capsules by mouth once daily at bedtime were on the MAR twice. [Divalproex Sodium 250 mg, Week 1-2, take 1 tablet in the morning and 2 tablets (500 mg) once daily at bedtime].

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, THE LOVING ONES ADULT FAMILY HOME II is or will be in compliance with this law and / or regulation on (Date) 3/7/25 .

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

Provider (or Representative) — Date: 3/7/25

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, interview, and record review, the Adult Family Home (AFH) failed to ensure medication kept in the office of the AFH and for 1 of 4 residents (Resident 3) remained in locked storage. This failure placed the ambulatory resident (Resident 3) at risk of accessing and taking medication not prescribed for their use.

Findings included...

During a visit on 02/13/2025 at 8:25 AM, observation showed Resident 3 lived in and received medication assistance from the AFH. Further observation showed Resident 3 ambulated independently in the AFH.

Observation on 02/13/2025 at 8:38 AM showed, the office in the AFH was located off the entryway and the office door was opened. Further observation showed the residents medication was stored in an unlocked cabinet in the office.

In an interview on 02/13/2025 at 8:39 AM, Staff C, Designee/Caregiver, stated that when they worked in the AFH the door to the office was kept unlocked. Staff C further stated that if they left the AFH they locked the office door.

Observation on 02/13/2025 at 8:41 AM showed Staff C opened a cabinet door in the entryway table and removed a key. Further observation showed Staff C unlocked the office door with the key.

In an interview on 02/13/2025 at 8:42 AM, Staff C stated that they kept the key to the office in the entryway table.

Resident 3
Observation on 02/13/2025 at 10:45 AM showed a container of Medicated Chest Rub on Resident 3's bedside table.

In an interview on 02/13/2025 at 10:46 AM, Resident 3 stated that they applied the Medication Chest Rub under their nose.

In an interview on 02/13/2025 at 10:47 AM, Staff D, Caregiver, stated that Resident 3 had a form of cancer and was currently undergoing Chemotherapy, a treatment for cancer. Staff D further stated that they would lock up Resident 3's Medicated Chest Rub.

A review of Resident 3's February 2025 pharmacy generated Medication Administration Record (MAR) showed no entry for Medicated Chest Rub.

In an interview on 02/13/2025 during the exit at 5:12 PM, Staff C stated that Resident 3's Representative must have provided the resident with the medication and had not informed AFH staff.

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, THE LOVING ONES ADULT FAMILY HOME II is or will be in compliance with this law and / or regulation on (Date) 3/7/25 .

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

Provider (or Representative) _____ Date 3/7/25

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 implement their medication disposal policy for 2 of 2 sampled residents (Resident 3 and Resident 4). This failure placed Resident 3 and Resident 4 at risk of a negative reaction or worsening of condition.

Findings included...

A review of the AFH's "Medication Disposal Policy" showed expired medications would be placed in the RX Destroyer, a chemical destruction container that converts solid and liquid medications into a non-retrievable form.

During a visit on 02/13/2025 at 8:25 AM, observation showed Resident 2 and Resident 3 lived in and received medication assistance from the AFH.

Resident 2
Observation on 02/13/2025 at 1:26 PM showed, in Resident 2's medication storage container,
-Melatonin 5 milligrams (mg), take 1 tablet by mouth at bedtime as needed for sleep. Further observation of Resident 2's Melatonin 5 mg showed an expiration date of 02/01/2025.

-Biotene Dry Mouth Rinse Mouthwash, swish and spit 15 milliliters (ml) by mouth or throat every 6 hours as needed for dry mouth as directed. Further review of Resident 2's Biotene Dry Mouth Rinse Mouthwash showed an expiration date of 12/28/2024.

In an interview on 02/13/2025 at 1:45 PM, Staff D, Caregiver, stated that they reviewed resident medication as often as they could.

Resident 3
Observation on 02/13/2025 at 2:05 PM showed, in Resident 3's medication storage container a bubble pack of "Ondansetron ODT" 8 mg, take 1 tablet (8 mg total) by mouth every 8 hours as needed for nausea/vomiting. Further observation of Resident 3's "Ondansetron ODT" 8 mg further showed an expiration date of 01/17/2025.

In an interview on 02/13/2025 at 2:00 PM, Staff D stated that the AFH's medication disposal policy was to put expired medication in the RX Destroyer.

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, THE LOVING ONES ADULT FAMILY HOME II is or will be in compliance with this law and / or regulation on (Date) 3/7/25 .

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

Provider (or Representative) — Date: 3/7/25

WAC 388-76-10650 Medical devices.

(2) Before a medical device with a known safety risk is used by a resident, the home must:

(a) Ensure an assessment has been completed that identifies the resident's need and ability to safely use the medical device;

(b) Provide the resident and his or her family or legal representative with information about the device's benefits and safety risks to enable them to make an informed decision about whether to use the device;

(c) Ensure the resident's negotiated care plan includes how the resident will use the medical device; and

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 1 resident (Resident 2) with a [redacted] had an assessment completed that identified the resident's need and ability to safely use the [redacted]. In addition, the AFH failed to provide Resident 2 or their Representative with information on the benefits and safety risks of the [redacted]. Further, the AFH failed to include in Resident 2's Negotiated Care Plan (NCP) how the [redacted] would be used. These failures prevented Resident 2 or their Representative from making an informed decision about whether to use the [redacted] and placed Resident 2 at risk of harm from staff not knowing how the resident used the [redacted].

Findings included...

During a visit on 02/13/2025 at 8:25 AM, observation showed Resident 2 lived in and received care from the AFH.

Observation on 02/13/2025 at 11:00 AM showed Resident 2 had a [redacted] in the up position. Further observation showed the [redacted] was on the left side of Resident 2's

[redacted] bed against the wall.

A review of Resident 2's NCP dated 05/10/2024 showed Resident 2 was admitted to the AFH on [redacted]/2022. Further review showed no information in Resident 2's NCP that the resident had a [redacted] or identified how the resident used the [redacted].

In an interview on 02/13/2025 during the exit at 5:12 PM, Staff C, Designee/Caregiver, stated that the AFH did not have an assessment that identified Resident 2's need and ability to safely use the [redacted]. Staff C further stated that Resident 2 had not been provided with the benefits or safety risks of [redacted] and that Resident 2's NCP did not include how the resident used the [redacted].

In a follow up phone interview on 02/19/2025 at 9:51 AM, Staff D, Caregiver, stated that Resident 2 had left side weakness and used the [redacted] for repositioning.

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, THE LOVING ONES ADULT FAMILY HOME II is or will be in compliance with this law and / or regulation on (Date) 3/7/25.

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

Provider (or Representative) — Date: 3/7/25

WAC 388-76-10720 Electronic monitoring equipment Audio monitoring and video monitoring.

(2) The home may video monitor and video record activities in the home, without an audio component, only in the following areas:

(a) Entrances and exits if the cameras are:

(i) Focused only on the entrance or exit doorways; and

(ii) Not focused on areas where residents gather;

(3) The home must notify all residents in writing of the video monitoring equipment. The home must:

(a) Identify in the written notification each person or organization with access to electronic monitoring; and

(b) Retain an acknowledgment that has been signed and dated by both the resident and the home that states in writing that the resident has received this notification.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure video recording did not include area's where the residents gathered and failed to provide 4 of 4 residents (Residents 1, 2, 3, and 4) and their Representatives with written notification of the video recording and kept a signed and dated copy with each residents' records. This failure caused the invasion of all 4 residents' privacy and the ability to make informed decisions.

Findings included...

During a visit on 02/13/2025 at 8:25 AM, observation showed Residents 1, 2, 3, and 4 lived in and received care from the AFH.

Observation on 02/13/2025 at 9:20 AM showed, a baby monitor affixed to the wall in the kitchen. Further observation showed the baby monitor was pointed in the direction of the family room and directly across from the recliner Resident 1 was seated in.

A review of Resident 2's records showed Resident 2 was admitted to the AFH on [redacted]/2022. Further review of Resident 2's records showed no signed and dated notification of the video monitoring equipment.

A review of Resident 3's records showed Resident 3 was admitted to the AFH on [redacted]/2021. Further review of Resident 3's records showed no signed and dated notification of the video monitoring equipment.

In an interview on 02/13/2025 at 9:21 AM, Staff C, Designee/Caregiver, stated that the camera was to determine which staff were in the AFH. Staff C further stated that the video went directly to their cell phone. In addition, Staff C stated that residents and their Representatives had not been notified in writing of the video monitoring. Staff C further stated that Resident 2 was aware of the video monitoring as they had observed the camera.

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, THE LOVING ONES ADULT FAMILY HOME II is or will be in compliance with this law and / or regulation on (Date) 3\7\25 .

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

Provider (or Representative) — Date: 3\7\25

WAC 388-76-10840 Emergency food supply.

(1) The adult family home must have an on-site emergency food supply that:

(d) Is sufficient, safe, sanitary, and uncontaminated.

This requirement was not met as evidenced by:

Based on observation and interview, the Adult Family Home (AFH) failed to ensure canned food kept in 1 of 1 closet (C1) was safe for resident consumption. This failure placed all residents (Residents 1, 2, 3, and 4) at risk of foodborne illness.

Findings included...

During a visit on 02/13/2025 at 8:25 AM, observation showed Residents 1, 2, 3, and 4 lived in and received care from the AFH.

Observation on 02/13/2025 at 9:37 AM showed the AFH stored the emergency food container in C1 along with the following canned goods, bamboo shoots expired 07/25/2020, 7 cans of garbanzo beans all with expiration dates of 05/10/2017, 2 cans of evaporated milk with expiration dates of 09/21/2019 and 03/11/2020, 2 cans of condensed milk both expired on 11/2020, 1 unlabeled dented can, and 3 cans of cranberry sauce with expiration dates of 03/11/2020, 12/16/2021, and 05/14/2022. In addition, observation showed the cranberry sauce with the expiration date of 03/11/2020 had leaked from the bottom of the can.

In an interview on 02/13/2025 at 9:45 AM, Staff D, Caregiver, stated that the AFH did not use canned goods often.

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, THE LOVING ONES ADULT FAMILY HOME II is or will be in compliance with this law and / or regulation on (Date) 3/7/25 .

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

Provider (or Representative) — Date: 3/7/25

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

COPY

03/04/2025

R DEOL LLC
THE LOVING ONES ADULT FAMILY HOME II
2315 S 254TH COURT
DES MOINES, WA 98198

RE: THE LOVING ONES ADULT FAMILY HOME II # 752109

Dear Provider:

The Department completed a full inspection of your Adult Family Home on 02/27/2025 and found that your home does not meet the Adult Family Home Licensing requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect the home to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Return the Plan/Attestation Statement and report with signatures to:

Dahl Kim, Field Manager
Residential Care Services
Region 2, Unit G
Preferred methods:

eFax: (253) 395-5071
Email: rcsregion2email@dshs.wa.gov
Optional method:
20425 72nd Avenue S, Suite 400
Kent, WA 98032

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-76-10375 Negotiated care plan Signatures Required. The adult family home must ensure that the negotiated care plan is agreed to and signed and dated by the:

(1) Resident; and

(2) Adult family home.

The AFH failed to have Resident 2 and Resident 4's Negotiated Care Plan (NCP) signed and dated within 30 days. Resident 2's NCP was dated 05/10/2024 and signed and dated on 09/15/2024. Resident 4's NCP was dated 09/15/2024 and signed and dated by the AFH on 09/15/2024 and signed and dated by Resident 2's Representative on 02/08/2025.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Ask for a informal dispute resolution meeting, according to the attached 'Informal Dispute Resolution' instructions; and
• Ask questions and provide written information to help clarify or dispute the deficiencies.

• Contact me for clarification of the deficiency or deficiencies found.

If You Have Any Questions:
• Please contact me at (253)234-6007.

Sincerely,

Dahl Kim

Dahl Kim, Field Manager

Region 2, Unit G
Residential Care Services

Enclosure

Plan
(Plan of Correction)

You Must:
Return the plan, on the enclosed report, within 10 calendar days after you receive this letter.

Include the following in your plan for each deficiency:
- The date you have or will correct each deficiency; and
- Provide a signature and date certifying that you have or will take corrective measures to correct each cited deficiency.

Send your plan to:
Dahl Kim, Field Manager
Residential Care Services
Region 2, Unit G
Preferred methods:
eFax: (253) 395-5071
Email: rcsregion2email@dshs.wa.gov
Optional method:
20425 72nd Avenue S, Suite 400
Kent, WA 98032

INFORMAL DISPUTE RESOLUTION [RCW 70.128]

You May:
Request an Informal Dispute Resolution (IDR) meeting within 10 working days after the date you receive this letter. You **must** use an **'IDR Request Form'** for **each** citation or enforcement you plan to dispute. You can find this form and directions on the IDR Adult Family Home web page at: https://www.dshs.wa.gov/altsa/idr

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Provider Process for Choosing a Panel or Traditional IDR:

You may only choose a **Panel IDR** if you are disputing **three or fewer** citations or enforcement actions. You may choose a **Traditional IDR** regardless of the number of citations or enforcement actions you intend to dispute. If you choose a

Panel IDR, all documents supporting your dispute must be submitted within **20 working days** after the date you receive this letter. For **Panel IDRs** the program will not consider any documents submitted after the **20 working day deadline**. For **Traditional IDRs** you should submit documents supporting your dispute at least **seven** days prior to the date of the IDR meeting.

Send your request and supporting documents to:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

The Loving Ones AFH II Plan of Action

Deficiency #1

Failed to ensure that 1 household member had a Washington state name and birth date background inquiry result prior to allowing unsupervised access to residents.

Action Taken:

Immediately corrected the deficiency—AFH manager has been instructed and retrained to conduct a name and date of birth background check for all household members, noncaregiving, and unpaid staff prior to having unsupervised access to residents.

Deficiency #2

Failed to ensure enough staff were available in the AFH to meet the residents' needs.

Action Taken:

Immediately corrected the deficiency – All AFH staff have been instructed and retrained to ensure there is an adequate number of staff per household to assist residents. Assigned staff will not leave the household during their designated shifts.

Deficiency #3

Failed to ensure 1 of 2 sampled staff had an initial Tuberculosis test completed within 3 days of employment and a second test completed within one to three weeks after the first.

Action Taken:

Immediately corrected the deficiency – AFH manager has been instructed and retrained to ensure that all incoming staff is directed to take an initial test within three days of

employment with a follow-up done 1-3 weeks after. Current employee records have been audited to ensure compliance with the two-step testing rule. Staff E has been directed to undergo a new two-step test with the first having to be completed before they return to work at the AFH. The second test will be completed 1-3 weeks following.

Deficiency #4

Failed to include in 1 of 2 sample resident Negotiated Care Plan medical devices used by the resident, how they are used, when they are used, as well as any assistance staff were required to provide. Also, failed to include in 1 of 1 resident a plan to ensure the resident did not have access to toxic substances and that they remained in locked storage. In addition, failed to ensure Resident 4's NCP included the resident's problem behaviors, staff interventions, and the symptoms the resident's psychopharmacological medication addressed.

Action taken:

Immediately corrected the deficiency – Resident 2's NCP was amended to include the use of a [redacted], how it is used, when it is used, and the directions for staff assistance. Resident 4's NCP was amended to include doctor's orders regarding her use of toxic substances while in the AFH. She is allowed to use nail polish under the direct supervision of caregivers. Caregivers were directed to keep nail polish in a locked storage box which is not accessible to residents. Additionally, Resident 4's NCP was updated to include her problem behaviors, staff interventions, and the diagnoses/symptoms that her psychopharmacological medication addressed.

Deficiency #5

Failed to ensure that care and services for 2 of 2 samples residents (Resident 2 and Resident 3) were provided in a safe manner and that resident preferences for 1 of 1 sampled resident did not endanger the resident's health or safety.

Action taken:

Immediately corrected the deficiency -- Staff have been instructed and retrained to manually log blood pressure levels and only give medication according to orders in the

MAR. For Resident 2, when the SBP measures less than 100 or HR less than 60 Metoprolol Succinate 50 mg should be held & when the SBP measures less than 100 Hydralazine HCL 50mg must be held. As shown in the statement of deficiencies document, Resident 2 was informed that medication cannot be delayed unless there is prior approval from the Primary Care Provider.

Staff have been instructed and retrained to give medications at the exact time that they have been written in the MAR unless otherwise ordered by PCP. Management has been instructed to check the MAR daily to ensure that it is accurate/complete and there are no accidental signings or errors.

Deficiency #6

Failed to ensure medication kept in the office of the AFH and for 1 of 4 residents (Resident 3) remained in locked storage.

Action taken:

Immediately corrected the deficiency – Management has been instructed and retrained to keep the AFH office door closed and locked at all times unless there is a staff member actively in the office. The key will be kept physically on a staff member (management or caregiver) at all times.

Management will ensure that residents' rooms are routinely checked for items that should not be in their possession (unauthorized medication, toxic substances, etc.) Management has also communicated with residents' families to reiterate the items that should not be brought in to the AFH or given to residents.

Deficiency #7:

Failed to implement medication disposal policy 2 of 2 sampled residents (Resident 3 and Resident 4).

Action taken:

Immediately corrected the deficiency – Management has been instructed and retrained to audit resident medications on a regular basis to ensure that expired medications are disposed of based on AFH policy.

Deficiency #8:

Failed to ensure that 1 of 1 resident (Resident 2) with a [redacted] had an assessment completed that identified the resident's need and ability to safely use the [redacted]. In addition, failed to provide Resident 2 or their representative with information on the benefits and safety risks of the [redacted]. Further, failed to include in Resident 2's NCP how the [redacted] would be used.

Action taken:

Immediately corrected the deficiency – Management has reached out to assessor to include [redacted] in Resident 2's assessment. AFH has provided Resident 2's Representative with the handout on benefits and safety risks of the [redacted]. AFH is awaiting on Representative's signature of acknowledgment. Resident 2's NCP has been updated to include the use of [redacted] and how it is being utilized.

Deficiency #9:

Failed to ensure video recording did not include areas where the residents gathered and failed to provide 4 of 4 residents and their representatives with written notification of the video recording and keep a signed and dated copy with each residents' records.

Action taken:

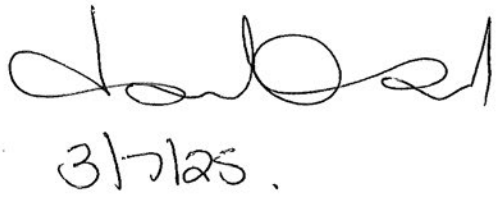
Immediately corrected the deficiency – All recording devices have been removed from use in the AFH. If these devices will be used in the future, prior written notification and approval will be obtained and kept in residents' records.

Deficiency #10:

Failed to ensure canned food kept in 1 of 1 closet (C1) was safe for resident consumption.

Action taken:

Immediately corrected the deficiency – Management has been instructed and retrained to audit emergency food storage on a weekly basis to ensure that expired food is disposed of. Any food that was listed as expired in the statement of deficiencies has been disposed of. AFH will ensure that there is an adequate supply of unexpired emergency food on-site.



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