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

ARGONNE INC
ARGONNE ADULT FAMILY HOME
1572 GRANT ROAD
EAST WENATCHEE, WA 98802

RE: ARGONNE ADULT FAMILY HOME # 752273

Dear Provider:

This document references Compliance Determination 27230 (08/03/2023), which included complaint number(s) 90033.

The Department completed a complaint investigation of your Adult Family Home on 08/03/2023 and found that your home does not meet the Adult Family Home Licensing requirements.

The department staff who did the inspection and provided consultation:

Brittney Shull, Community Complaint Investigator

A licensor may consult with a provider when a violation of the Washington Administrative Code (WAC) or Revised Code of Washington (RCW) is found, but it is not cited in the Statement of Deficiencies. Violations may not be cited when it is a first-time violation of statute or rule with minimal or no harm to residents. A consult does not require a follow-up visit.

Consultation:

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;

The home failed to assess a resident's ability to safely use [redacted].

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:
- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:
- Inspect the home to determine if you have corrected all deficiencies.

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 (509)572-7394.

Sincerely,

Michelle Closner

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

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 the address below or email to rcsidr@dshs.wa.gov:

Adult Family Home IDR Program
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

Residential Care Services
Investigation Summary Report

Provider/Facility: ARGONNE ADULT FAMILY HOME
Provider Type: Adult Family Home
License/Cert.#: 752273
Intake ID: 90033
Compliance Determination #: 27230
Region/Unit #: RCS Region 1 / Unit C
Investigator: Brittney Shull
Investigation Date(s): 07/27/2023 through 08/03/2023
Complainant Contact Date(s): 07/21/2023, 07/24/2023, 08/03/2023

Allegation(s):

1) AFH staff are not managing [redacted] correctly.
2) The named resident's [redacted] has not been changed.
3) Other residents are using the named resident's [redacted].
4) The staff may not be giving mediations as prescribed to the named resident.

Investigation Methods:

Sample:	Total residents: 6 Resident sample size: 2 Closed records sample size: 0
Observations:	Residents, Staff to resident interaction, Resident to resident interaction, [redacted] devices, Medication storage and supply, Medication pass.
Interviews:	Residents, Staff and others not associated with the home.
Record Reviews:	Resident record, Personnel records, Oxygen Safety Education, Medication Administration Record, Physician orders.

Investigation Summary:

4) Record review and interview showed that the named resident had an adequate and accurate supply of medication. A medication pass was observed to be timely and accurate. Record review and interview showed that a process was in place to ensure that the resident would continue to have an adequate supply of medication. 1, 2, 3) Observation, record review and interview showed that the home was aware of standard oxygen procedure and precautions. Resident interview and observation showed that residents were only using their own [redacted] devices and supplies. Interview showed that the named resident's family member was responsible for ensuring adequate [redacted] supplies. It further showed that there was an incident in which the [redacted] equipment was functioning, but the regulator was difficult to adjust. The named resident's family member was able to get the regulator replaced. Observation, record review and interview showed that another resident was not assessed for their ability to safely use [redacted]. Failed Practice Identified, WAC 388-76-10650(2)(a), reference consultation dated 08/03/2023.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A