STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Bellevue Elderly Care LLC

Bellevue Elderly Care LLC
102 162nd Ave SE
Bellevue, WA 98008

RE: Bellevue Elderly Care LLC License # 753136

Dear Provider:

This letter addresses Compliance Determination(s) 50227 (Completion Date 11/13/2024) and 48638 (Completion Date 10/18/2024).

The Department completed a follow-up inspection of your Adult Family Home on 11/13/2024 and found that you have corrected the violations listed in the Full report dated 10/18/2024. Your home is back in compliance as of 10/30/2024 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10430-1, WAC 388-76-10430-2-c, WAC 388-76-10430-2-d

The Department staff who did the on-site verification:
Claire Fleming, Long Term Care Surveyor
Alfredo Brown, Allied Health Field Manager

If you have any questions, please contact me at (253)341-7376.

Sincerely,

Alfredo Brown

Alfredo Brown, Field Manager
Region 2, Unit K
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 10/14/2024 and 10/14/2024 of:
Bellevue Elderly Care LLC
102 162nd Ave SE
Bellevue, WA 98008

The following sample was selected for review during the unannounced on-site visit: 2 of 6 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Rivi Stella Perez

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit K
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Alfredo Brown
Residential Care Services

10/30/2024
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

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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) 11/1/2024 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 observation, record review and interview, the Adult Family Home (AFH) failed to ensure 1 of 2 sampled residents (Resident 2) received medication as ordered by their physician and the medication log (ML) included the updated dosage of the medication and the initials of the staff who had administered the medication. These failures resulted to a medication error for Resident 2.

Findings included...

Review of the AFH records on 10/14/2024, showed Resident 2 admitted to the AFH on [redacted]/2024 with multiple diagnoses and on hospice care.

During an interview on 10/14/2024 at 9:37 AM, Staff A, Entity Representative/Resident Manager, stated that Resident 2's ability to take medication varied between medication assistance (caregivers would prepare the medication and the resident had the ability to put the medication in their mouth with cueing and/or supervision) to medication administration (resident totally dependent on caregiver for preparation and administration).

Observation and record review of the pharmacy supply for Quetiapine Fumarate (an antipsychotic medication which are medications to treat psychosis, a collection of symptoms that affect your ability to tell what is real and what is not) on 10/14/2024 at 3:01 PM, showed a bubble pack with a date of 10/02/2024. The prescription label on the bubble pack showed, "Take 1 tablet (50 mg [milligram]) by mouth 2 times daily for agitation or restlessness". The bubble pack had a handwritten scheduled time of "8AM" and "8PM". The bubble pack showed 11 of the 15 tablets had been punched out (or administered)

Provider (or Representative) Date

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Record review of Resident 2's October 2024 ML, received on 10/14/2024 at 9:32 AM, showed no order for Quetiapine Fumarate: Take 1 tablet (50 mg) by mouth 2 times daily at 8:00 AM and 8:00 PM.

During an interview on 10/14/2024 at 3:07 PM, Staff A stated that they did not understand the order changes from hospice for Resident 2''s scheduled dosage of the Seroquel.

Record Review of the orders from hospice, dated 10/01/2024, showed the following orders for the Seroquel (brand name for Quetiapine):

- "Discontinue Seroquel 100 mg 2s [should be 2x for twice] daily scheduled".
- "Start Seroquel 100 mg 1x daily AM".
- "Start Seroquel 50 mg 2x daily evening and HS [bedtime]".
- "Start Seroquel 150 mg 1x at bedtime 100 mg tablet and 1 50 mg tablet HS".
- "PRN [as needed] orders remain active".

The bedtime dose was changed from 100 mg to 150 mg daily.

Observation on 10/14/2024 at 3:10 PM, showed Staff A talking with the hospice nurse for Resident 2 to clarify the dosage order for the scheduled Seroquel. Observed the hospice nurse telling Staff A, over the phone, the current order for Seroquel which was as follows: 100 mg in AM [8:00 AM], 50 mg at 5:00 PM and 150 mg at HS [8:00 PM].

Observation and record review on 10/14/2024 at 3:13 PM, showed a folded copy of an October 2024 ML for Resident 2. The folded copy of the October 2024 ML showed a written order dated 10/01/2024 stating, "Quetiapine Fumarate 50 mg tablet. Generic for Seroquel. Take 1 tablet (50 mg) by mouth 2 times daily for agitation or restlessness." The order showed a scheduled time of 8:00 AM and 8:00 PM and there were no caregiver initials from 10/1/2024 to 10/14/2024 to indicate the medication was administered. This page of Resident 2's October 2024 ML was not part of the ML provided at 9:32 AM.

During an interview on 10/14/2024 at 3:15 PM and 3:19 PM, Staff A stated they were following the pharmacy orders to give 50 mg of Quetiapine at 8:00 AM and 8:00 PM. Staff A stated they did not sign for the 50 mg twice a day dose in the October 2024 ML. Staff A stated they did not catch the order change [on 10/01/2024].

Further observation of the supply for the scheduled Quetiapine on 10/14/2024 at 3:15 PM, showed the following labeled bubble packs:

- Rx [prescription] #743511, dated 09/30/2024, Quetiapine Fumarate 100 mg. "Take

1 tablet (100mg) by mouth 2 times daily for agitation." There was a handwritten schedule for 8:00 AM and 8:00 PM.

- Rx 7433536, dated 09/30/2024, Quetiapine Fumarate 50 mg. "Take 1 tablet by mouth every afternoon for agitation." There was a handwritten schedule for 5:00 PM.
- Rx 7434243, dated 10/02/2024, Quetiapine Fumarate 50 mg. "Take 1 tablet (50 mg) by mouth 2 times daily for agitation or restlessness." There was a handwritten schedule for 8:00 AM and 8:00 PM.

During an interview on 10/14/2024 at 3:20 PM, Staff A stated that they followed the pharmacy label on the bubble pack to give Quetiapine 50 mg twice daily. Staff A stated that they did not understand the order that came from the hospice. Staff A stated the pharmacy had not received the order from the hospice to discontinue the dose for 100mg twice a day.

During an interview on 10/14/2024 at 3:25 PM, Staff A stated that Resident 2 had received the following scheduled doses for Quetiapine since 10/1/2024: 150 mg for 8:00 AM, 150 mg for 8:00 PM and 50 mg for 5:00 PM.

During an interview on 10/14/204 at 3:36 PM, Staff A stated that Resident 2 had received a total dose of 350 mg for the scheduled dose. Staff A stated Resident 2 had received an extra 50 mg dose of Quetiapine from the current prescribed dose and had a medication error.

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, Bellevue Elderly Care LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Provider (or Representative) Date

Bellevue Elderly Care LLCs Plan of Correction

Issue identified on October 14,2024 inspection.

During the annual inspection, Rivi Perez BSN, RN identified an error in my Medication Administration Records (MARs). This issue involved a resident with severe agitation and behavioral problems, leading to frequent medication adjustments. The most recent change, ordered by the RN from Continuum Hospice, was unclear and caused miscommunication with the pharmacy and myself. The pharmacy interpreted the order to discontinue 100 mg BID of Seroquel and replace it with 50 mg BID. However, we misunderstood this instruction and added 50 mg to the existing 100 mg dosage. The medication was received by staff, who assumed it was an addition, and the MARs were left by the printer instead of being filed in the medication book, leading to the oversight.

Steps taken:

1. Upon discovering the mistake, I immediately asked Rivi if I could address the issue right away, as I prefer not to leave problems unresolved.

2. I contacted the pharmacy to clarify the situation. They had understood the order to discontinue Seroquel 100 mg BID and replace it with 50 mg BID. They also mentioned that the RN's instructions were unclear and raised some concerns, but they attributed it to the frequent changes in the resident's medication routine.

3. I then reached out to the RN for clarification. She was initially unsure about her own instructions. Even Rivi noted the unusual nature of the order. The RN clarified that her intended prescription was 100 mg in the morning, 50 mg in the afternoon, and 150 mg at night. We informed her that we had mistakenly administered 150 mg in the morning, which was 50 mg more than intended. To my surprise, she suggested altering the dosage to 150 mg in the morning, 50 mg in the afternoon, and 150 mg at night. I asked her to confirm this plan with the doctor and get back to me to ensure everyone was aligned. This conversation took place around 3 PM.

4. The RN called back at 4:10 PM, leaving a message to clarify the issue and instructed me to inform the psychiatric doctor during the resident's first appointment. She called again at 4:30 PM to discuss the situation further. I explained that her initial phone order to the pharmacy had caused confusion. She referred to it as her "little oopsie" I had to be assertive with her that is not ok, insisting that if the doctor approved the revised dosage, she needs to inform the pharmacy and myself to make sure we are all on the same page.

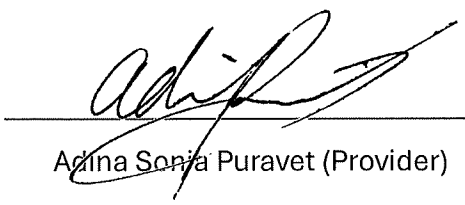
5. Later that evening, at 7 PM, I received the updated orders for 150 mg in the morning, 50 mg in the afternoon, and 150 mg at bedtime. I updated the MARs accordingly and confirmed the changes with the pharmacy. The next day, I contacted the pharmacy for advice on preventing such issues in the future. They recommended requesting clearer orders from Continuum RN, noting that similar mistakes had occurred with other residents before. While I usually catch such errors, this one slipped through. The Continuum RN made other mistakes, but I corrected them the day the order came in.

6. After the inspector left that evening, I called the resident's daughter POA to explain what had happened and apologized for the mistake. I also inquired if it was possible to work with a different RN who makes fewer prescription errors, but she said that was not an option.

7. Moving forward, I will be more vigilant about medication changes and will always seek clarification from Continuum Hospice or any other medical place for any orders I do not understand. I am grateful that the resident was not affected at all despite the medication oversight.

Plan of Correction:

- **Medication Delivery**: When any medication is delivered from the pharmacy, all staff will text 206-349-0901 (Adina, Manager). I will personally triple check the orders.
- **Clarification of Orders**: For any unclear orders, I will ensure to seek clarification im mediately from the RN or doctor to avoid any misunderstandings.
- **Medication Administration Reminder**: When administering medication to resident s, always verify:
    1. The name and DOB of resident
    2. The name of the medication,
    3. The time that needs to be administered
    4. The dosage,
    5. The route



Adina Sonja Puravet (Provider)

11/1/2024

Date