



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

10/18/2024

Senior Best Care Inc
Senior Best Care Inc.
21210 132ND AVE SE
KENT, WA 98042

RE: Senior Best Care Inc. # 753621

Dear Provider:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 48105 (Completion Date 10/18/2024) and 43940 (Completion Date 07/23/2024).

The Department completed a follow-up inspection of your Adult Family Home on 10/18/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

- (1) The care and services identified in the negotiated care plan.
- (3) The care and services in a manner and in an environment that:
 - (a) Actively supports, maintains or improves each resident's quality of life;
 - (b) Actively supports the safety of each resident; and
- (4) Services by the appropriate professionals based upon the resident's assessment and negotiated care plan, including nurse delegation if needed.

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

The Department staff who did the On Site verification:

This document was prepared by Residential Care Services for the Locator website.

Angelica Rios, ALF Licenser
Michele Grumke, AFH Licenser

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

Sincerely,



Lydia Owusu-Acheampong, 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

Statement of Deficiencies	License #: 753621	Compliance Determination # 43940
Plan of Correction	Senior Best Care Inc.	Completion Date
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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 07/09/2024 and 07/09/2024 of:

Senior Best Care Inc.
21210 132ND AVE SE
KENT, WA 98042

This document references the following SOD dated: 07/23/2024

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:

Angelica Rios, ALF Licenser

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

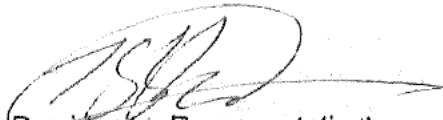
08-02-2024

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.

This document was prepared by Residential Care Services for the Locator website.

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 Provider (or Representative)

08/03/24
 Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

- (1) The care and services identified in the negotiated care plan.
- (3) The care and services in a manner and in an environment that
 - (a) Actively supports, maintains or improves each resident's quality of life;
 - (b) Actively supports the safety of each resident; and
- (4) Services by the appropriate professionals based upon the resident's assessment and negotiated care plan, including nurse delegation if needed.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to ensure that 4 of 4 residents' (Residents 1, 2, 3 and 4) received care and services required to ensure safety and improve their quality of life. Additionally, the residents' Negotiated Care Plans' (NCP) did not include all required care needs and assessed nurse delegation (a nurse directs another person to perform nursing tasks and activities) tasks. These failures placed Residents 1, 2, 3 and 4 at risk of harm from worsening condition and decreased quality of life from not receiving required care and services.

Findings included...

Review of the department's records showed a condition was imposed on the AFH's license on 5/24/2024, to hire a Registered Nurse Consultant (RNC) to assist in ensuring residents' NCPs were comprehensive and included nurse delegation needs. The condition also required the RNC to provide to all staff, including the Entity Representative, training regarding requirements for nurse delegation and NCPs.

Review of an email correspondence received by the department on 07/08/2024 at 4:14 PM from a RNC, hired by the AFH, showed that Staff A, Entity Representative/Resident Manager received nurse delegator training from the RNC and the AFH's nurse delegator. The RNC's notes further showed Staff A did not follow the training techniques and nurse delegation protocols. Additional review showed that Staff A was not aware of resident care needs and did not include nurse delegated care in residents' NCPs.

During a visit on 07/09/2024 at 10:10 AM, observation showed Residents 1, 2, 3 and 4, lived in and received care from the AFH. In addition, observation showed Staff A, worked and provided care to the residents.

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Resident 1

Review of Comprehensive Assessment Reporting and Evaluation (CARE) current initial assessment dated of 02/22/2024, showed the following:

-Resident 1 was admitted to the AFH on [REDACTED]/2024.

-Resident 1 required nurse delegation for wound care.

-Bed mobility showed Resident 1 required ongoing level of support which included two-person assistance. Caregiver instructions stated, "Provide assistance at client's request, physically assist with positioning in bed, monitor pressure points daily, Reposition client at least every two hours, Use pillows/ towels for support."

-Transfer status showed Resident 1 required a two-person physical assist due to weakness.

-Medication management showed Resident 1's "Ability fluctuates, cannot open containers, Poor - coordination, forgets to take medications, Unable to read/see labels." Caregivers were instructed to "provide assistance at client's request, Document medication taken, Hand medication in cup or bowl, inform client of each medication given, Open containers, Place medication in client's hand, Re-order medications, Report adverse reactions."

-Treatments/Programs/Therapies showed "dressing needed if wounds open but need to monitor left shin area, left index finger & coccyx and maintain preventative measures including keeping area clean as well as coccyx after bowel movements." Additionally, use an external catheter as needed.

-Mental/Physical Health stated Resident 1 "inhaler was not used during hospital, but client will use as needed."

Review of Resident 1's signed NCP dated 04/18/2024, contained handwritten notes showed that their plan of care differed from Resident 1's assessment.

-Bed mobility/Transfer showed Resident 1 was a one person assist. ✓

-Medication management showed Resident 1 had no nurse delegation needs, and under caregiver's support, no direction given, and had "N/A" written.

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-Treatment/Program/Therapies showed "SBA" written under resident strengths. No explanation was provided.

-Medication management stated that Resident 1 was able to use their inhaler. Under caregiver's support, no direction given, and had "N/A" written.

-Oral and topical medications, stated under the Resident strength that they were aware to take their medication. Further review showed caregiver support included no instruction for oral and topical medications.

- Additional review showed instruction for caregiver to give medications during scheduled times and checked "5R", with no other information provided.

-Self-administration for inhaler showed "resident able to perform himself" under resident strengths and "N/A" under caregiver's support.

Review of Resident 1's June 2024 pharmacy-generated MAR showed Resident 1 was prescribed, Bisacodyl 10 mg suppository (for constipation), unwrap and insert 1 suppository rectally daily as needed for constipation if no bowel movement in 24 hours. There were no nurse delegation instructions for the prescribed suppository in Resident 1's NCP.

Review of the AFH's nurse delegation visit summary dated 06/24/2024 showed Resident 1 required nurse delegation for topical medications and suppository.

Review of an unsigned NCP dated 04/18/2024, showed that Resident 1 required nurse delegation for topical medication. Further review showed no information regarding the prescribed suppository that required nurse delegation. Additional review showed that caregivers ensured Resident 1 had their inhaler easily accessible for independent use.

Review of Resident 1's medication orders dated 07/09/2024 showed inhaler was not included.

During an interview on 07/09/2024 at 1:35 PM, Staff A stated that they were working on an updated NCP for Resident 1.

Observation on 07/09/2024 at 11:58 AM, showed Resident 1's [REDACTED] had a one-quarter length [REDACTED] loosely tied onto the right side of the bed frame and leaning away from the bed. Further observation showed the [REDACTED] was in the up position with a 3.5-inch gap between the mattress and [REDACTED]. Department Staff were able to move the

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loose [REDACTED] in all directions.

During an interview 07/09/2024 at 12 PM, Resident 1 stated that they used their [REDACTED] every day to turn in their bed and lean over to reach for their personal items near their bed. Resident 1 further stated that the [REDACTED] had been loose for over 2 months and understood that it may need to be removed. ✓

Review of a signed NCP with handwritten notes dated 04/18/2024 and of an unsigned NCP dated 04/18/2024, showed that caregivers encouraged Resident 1 to turn and change position to prevent and heal wounds. Further review of both NCPs showed no information on Resident 1's use of a [REDACTED].

Resident 2

Review of Resident 2's CARE Current initial assessment completed on 05/22/2024, showed the following:

- Resident 2 was on the meaningful day program (a program that offers individualized activities to reduce challenging behaviors). X
- Resident 2 required nurse delegation for topical medications. ✓
- Under instructions for positioning in bed, it was stated that Resident 2 needed to be "repositioned at least every 2 hours." ✓
- Skin/Foot problems notes stated, "Discussed skin issues and pressure sores prevention. No pressure sores or any skin breakdown was reported. The skin is intact at all pressure points. Informed the client and the AFH provider about the need to reposition regularly, the client agrees to have the AFH provider check all pressure points daily. AFH provider agreed to immediately contact PCP in case of any skin issues."

Review of Resident 2's signed NCP dated 12/12/2023 showed the following:

- Resident 2 was admitted to the AFH on [REDACTED]/2023.
- Review of nurse delegated tasks showed Resident 2 required nurse delegation for topical medications. Further review showed caregivers needed to "monitor skin use, and reports to office as required." No information on nurse delegated oral medications were provided in the NCP.

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-Treatments/Programs/Therapies showed no information that Resident 2 was on the Meaningful Day program.

-Bed mobility/Transfer showed caregivers were to "to help and encourage resident to turn as tolerated. Caregiver to remind residents of the importance of changing position to prevent and heal wounds. Caregiver to make sure call light in within reach when in the bed or recliner. Caregiver to put wedge time to time, reposition frequently to prevent bed sore." No details were provided on frequency.

-Toileting/Continence issues showed caregiver was required to monitor pressure point.

-Personal hygiene showed "Caregiver to help resident with all personal hygiene needs. Caregiver to move resident slowly to prevent discomfort during care. Caregiver to premedicate resident to decrease discomfort. File and clean the nail as needed." No other caregiver instruction details were provided.

During a visit on 07/09/2024 from 10:10 AM through 2:55 PM, observation showed Resident 2 laid in their bed. Observation showed Resident 2 was not repositioned by AFH staff throughout the visit.

During an interview on 07/09/2024 at 11:24 AM, Staff A stated that they are working on updating Resident 2's NCP. Staff A further stated they were completing an updated NCP for Resident 2 at the request of the NC. Additionally, Staff A stated that Resident 2 did not have any current skin issues.

Observation on 07/09/2024 at 11:56 AM showed Resident 2's fingernails had brown matter under each nail on their right hand. Further observation showed nails were uneven and about a half an inch long.

Review of nurse delegation visit summary dated 06/26/2024 showed that Resident 2 was delegated for topical medications, oral medication administration and as needed medications. Further review showed a full body skin assessment was performed and an 8-inch warm red boil on their posterior thigh was observed. This observation resulted in urgent care home visit for Resident 2 on 06/30/2024 suggested by the nurse delegator.

Review of aftercare instructions for Resident 2's home doctor visit on 06/30/2024 showed Resident 2 was treated for a skin infection. Further review showed Resident 2 was prescribed antibiotics and instructions to "continue to cover open wound with dressing."

Resident 2's current NCP did not show this updated skin care instructions.

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Resident 3

Review of Resident 3's CARE current assessment completed on 06/21/2024, showed the following:

- Resident 3 was insulin dependent [use on Insulin (liquid solution injected under the skin) to control blood sugar]
- Medication management showed Resident 3's medications "must be administered" because their ability fluctuated.
- Required nurse delegation for treatments and glucose monitoring.
- Treatments showed Resident 3 used [REDACTED] or [REDACTED] and needs assistance with cleaning and upkeep of machine.
- Treatment/Program/Therapies showed "AFH oversight/reminder" for blood glucose monitoring.
- Memory and cognitive performance showed that Resident 3 had short term memory problem and forgetful. Caregiver instructions stated, "set up calendar, give gentle verbal reminders." Further review showed that Resident 3 "experienced some difficulty in decision making when faced with new tasks or situations."
- Activities of daily living showed that Resident 3 required "extensive assistance, One-person physical assist."
- Bed mobility showed caregivers were required to provide assistance at Resident 3's request and provide physical assistance with positioning in bed.
- Diabetic foot care instructions stated "keep client's feet clean and dry and look at the feet every day for skin and nail changes. Podiatrist trims toenails, caregivers complete diabetic foot care."

Review of Resident 3's signed NCP dated 10/10/2023 showed the following:

- Resident 3 was admitted to the AFH on [REDACTED]/2019.

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-Medication management stated "Able to keep and administer their own medicine. Caregivers give medication to resident, open bottle and give meds as directed by doctor and N.D."[sic]

-Nurse delegation showed topical and inhaler use was nurse delegated. Additional review showed no information on insulin injections and glucose monitoring.

-Body care showed Resident 3 required assistance for foot and skin care, no caregiver instruction was provided.

-Bed mobility/transfer showed Resident 3 was dependent, no information and no instruction for caregivers was provided.

-Mobility showed Resident 3 was dependent, no information and no instruction for caregivers was provided.

-Physical enabler stated "No walker. Walker use only spot got stand or transfer, one person can hold walker, other caregiver help to transfer."

-Treatment/Therapies showed health issues to monitor included oxygen use, pain, and weight loss/gain. No information was provided on resident use of [REDACTED] or [REDACTED] machine.

-Cognitive status showed a check marked for sleep disturbance, short-term memory impairment, long-term memory impairment, resistive, depression and anxiety. Further review showed decision making was left unmarked. Additionally, there was no description of behaviors, and no caregiver instructions were provided.

Review of an unsigned NCP dated 06/12/2024 showed Resident 3 was nurse delegated for topical medication. Further review showed Resident 3 administered their own injection and a nurse delegated caregiver was required to follow nurse delegator instructions to assist Resident 3 with their insulin injections in the event of an emergency. Additional review showed no information on tracking Resident 3's medication and glucose monitoring.

During an in interview on 07/09/2024 at 10:39 AM, Staff A stated that Resident 3 did not need nurse delegation because they were independent. Staff A further stated that they left a MAR in Resident 3's room for Resident 3 to note their administered insulin injections. Additionally, Staff A stated they were working on completing Resident 3's updated NCP with the RNC.

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Review of Resident 3's June 2024 MAR on 07/09/2024 at 10:47 AM, showed no information for the 07/09/2024 8 AM glucose reading and insulin dose. Further review showed no medication were checked for 07/07/2024, 07/08/2024 and 07/09/2024. Further review showed handwritten notes on different sheets of post it notes in Resident 3's file that included glucose levels for Resident 3 and Resident 4. The notes were dated 07/07/2024 and 08/07/2024.

Observation on 07/09/2024 at 10:47 AM, showed Staff A called Resident 3 on their phone and asked if they had taken their medication that morning, asked for their glucose level, and the administered Insulin dose. Additional observation showed Staff A writing the provided information in Resident 3's MAR.

Resident 4

Review of CARE showed Resident 4's Current Annual Assessment dated 01/02/2024 showed the following:

- Resident 4 was Insulin dependent.
- Medication management showed Resident 4 required assistance with medication at resident's request.
- Resident 4's Assessment showed that they required nurse delegation for inhaler, cream, ointment, and as needed pain patch.
- Treatment/Program/Therapies showed that Resident 4 required glucose monitoring and "libre till falls out and then uses strips."
- Care planning for sleep stated, "wakes up with pain nightly, and toileting."

Review of Resident 4's "Resident Intake and NCP" dated 04/20/2023 showed the following:

- Resident 4 was admitted to the AFH on [REDACTED]/2020.
- Check mark for Dementia and specialty needs with no further caregivers' instructions. 
- Further review showed Resident 4 required nurse delegation for Foley catheter care, Diabetic monitoring, and insulin administration. Additional review did not show any information on catheter care, Diabetic monitoring, and insulin administration.

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-Self-administration showed a check mark for oral, inhaler and injections and stated Resident 4 "can read and can manage their own prescribed medication." It stated that caregiver provided medication with a glass of water. ✓

-Self-medication section included a check mark for self-medication assistance with oral, topical and medication organizer. No caregiver instruction was provided.

-Administration section states caregiver is to provide Resident 4 with insulin from Resident 4's room refrigerator. No information on glucose monitoring was provided.

-Personal hygiene showed Resident 4 required assistance and no caregiver instruction was provided.

-Dressing showed Resident 4 required assistance and no caregiver instruction was provided.

-Cognitive status showed a check marked for sleep disturbance, short-term memory impairment, long-term memory impairment, depression and anxiety. Further review showed decision making was left unmarked. Additionally, there was no description of behaviors, and no caregiver instructions were provided.

During a phone interview on 07/16/2024 at 1:20 PM Collateral Contact 1, Nurse Delegator, stated that Resident 4 could be resistant to care, and required monitoring and sometimes declined care. CC1 further stated that Resident 4 did not want to receive any staff assistance with nurse delegated tasks. Resident 4's NCP, did not show this refusal, and caregiver instruction on how to handle the resistance and resident's refusal.

During an interview on 07/09/2024 at 10:39 AM, Staff A stated that information on delegated tasks were not included in Resident 4's NCP because they were independent and AFH staff did not provide care to Resident 4. Staff A additionally stated that Resident 4 stored all their medications in their room.

During a phone interview on 07/17/2024 at 3:38 PM, CC2, stated they currently provide medical care to Resident 4. CC2 further stated that Resident 4's ability is gradually declining, and they would advise Resident 4 to allow the AFH to store their narcotic medication. CC2 additionally stated that they were not aware AFH staff were not monitoring Resident 4's self-administered medications, including Insulin and blood glucose monitoring.

This is uncorrected deficiency previously cited on 05/13/2024 for subsections (1) and (3)

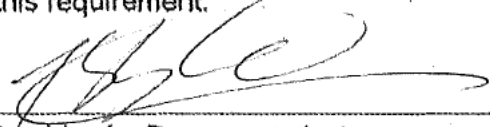
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(A)(B).

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, Senior Best Care Inc. is or will be in compliance with this law and / or regulation on (Date) 08/03/24.

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


 Provider (or Representative)

08/03/24
 Date

WAC 388-76-10490 Medication disposal Written policy Required. The adult family home must have and implement a written policy addressing the disposal of unused or expired resident medications. Unused and expired medication must be disposed of in a safe manner for:

- (1) Current residents living in the adult family home; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to implement their medication disposal policy for 1 of 4 residents (Resident 1). This failure placed Resident 1 at risk of decreased effectiveness from taking expired medication.

Findings included...

Review of the AFH's undated "Medication Disposal Form/Policy" showed medications were disposed by mixing with coffee grounds, kitty litter, or with the RX Destroyer (chemical destruction liquid that converts solid and liquid medications into a non-retrievable form).

During a visit on 07/09/2024 at 10:10 AM, observation showed Resident 1 lived in and received medication assistance from the AFH.

Review of Resident 1's unsigned NCP dated 04/18/2024, showed that caregivers ensured Resident 1 had their inhaler easily accessible for independent use.

On 07/09/2024 at 11:58 AM, observation showed Resident 1's an Albuterol inhaler

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(increases airflow to the lungs) on their bed side table. Further observation showed April 2019 as the expiration date.

In an interview on 07/09/2024 at 11:58 AM, Resident 1 stated that they last used the inhaler about 3 weeks ago. Resident 1 further stated that the AFH staff were aware that they used the inhaler as needed.

This is uncorrected deficiency previously cited on 05/13/2024 for subsection (1).

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, Senior Best Care Inc. is or will be in compliance with this law and / or regulation on (Date) 08/03/24.

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


Provider (or Representative)

08/03/24
Date



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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05/13/2024

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 04/23/2024 and 04/24/2024 of:

Senior Best Care Inc.
21210 132ND AVE SE
KENT, WA 98042

This document references the following complaint number(s): 127458, 128232, 129887

The following sample was selected for review during the unannounced on-site visit: 2 of 5 current residents and 1 former residents.

The department staff that investigated the Adult Family Home:

Michele Grumke, AFH Licenser
Angelica Rios, ALF Licenser
Ivy Mordo, Nursing Consultant Institutional
Vadim Panitkov, NCI

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

05/24/2024

Date

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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)

06/10/24
Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

- (1) The care and services identified in the negotiated care plan.
- (3) The care and services in a manner and in an environment that:
 - (a) Actively supports, maintains or improves each resident's quality of life;
 - (b) Actively supports the safety of each resident; and
- (4) Services by the appropriate professionals based upon the resident's assessment and negotiated care plan, including nurse delegation if needed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure they had nurse delegation (a state program that allows nursing assistants working in certain settings, like AFH, to perform certain tasks, like administration of prescribed medicines, normally performed only by licensed nurses) in place and included in the Negotiated Care Plans' (NCP) for 5 of 5 residents (Residents 1, 2, 3, 4, and 5) and 1 of 1 Former Resident (FR) who had been assessed as requiring nurse delegation. This failure resulted in unqualified staff performing undelegated nursing tasks during a prolonged absence of Staff A, Entity Representative/Resident Manager from the AFH, placing all residents at risk of harm and worsening condition.

Findings included...

In a phone interview on 04/22/2024 at 1:15 PM, Collateral Contact 2 (CC2) stated that they had provided notification to Staff A rescinding their nurse delegation oversight to the AFH on 04/15/2024, effective 04/19/2024. CC2 further stated that on 04/14/2024 they arrived at the AFH and found undelegated staff working in the AFH. CC2 stated that they determined one undelegated staff had trained another staff to provide residents with their medications. Additionally, CC2 stated that they were told Staff A was out of the country. CC2 further stated that they rescinded nurse delegation due to risks undelegated staff had placed on the residents, by providing medication without the required training and registered nurse oversight. CC2 stated that they did not know when or what medications the residents had received.

During a visit on 04/23/2024 at 10:04 AM, observation showed Residents 1, 3, 4, and 5

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lived in and received medication assistance or medication administration from the AFH. Further observation showed Resident 2 was not in the AFH. In addition, observation showed Staff A and Staff C, Caregiver, worked in and provided care to the residents.

In an interview on 04/23/2024 at 10:12 AM, Staff A stated that Resident 2 had been admitted to a local health facility for scheduled surgery on [REDACTED]/2024 and would be returning to the AFH soon. Staff A further stated that Former Resident (FR) had recently discharged from the AFH [on [REDACTED] 2024].

In an interview on 04/23/2024 at 1:15 PM, Staff C stated that Staff D, Caregiver, was nurse delegated.

In an interview on 04/23/2024 at 3:37 PM, Staff A stated that the nurse delegator had rescinded delegation. Staff A provided Department Staff (DS) with a black binder with all the resident's notification to rescind nurse delegation.

In an interview on 04/23/2024 at 3:40 PM, DS requested the residents nurse delegation paperwork that had been in effect prior to 04/15/2024. Staff A stated that it was not in their office and that the nurse delegator must have taken it. Staff A further stated that maybe they had misplaced it.

In a follow-up phone interview on 04/29/2024 at 11:51 AM, CC2 stated that they had never delegated Staff C, Caregiver, Staff D, Caregiver, or Staff E, Caregiver, to perform nursing delegated tasks for residents in this AFH.

In an interview on 04/30/2024 at 3:14 PM, Collateral Contact 3 (CC3) stated that they had agreed to be the designee for Staff A while they were out of the country. CC3 further stated that they went to the AFH every 2-3 days, checked in with the residents, and spoke with staff. Additionally, CC3 stated that they were told Staff A was taking care of everything online and was speaking with staff in the AFH daily. CC3 stated that Staff C, Staff D, and Staff E, worked in the AFH while Staff A was out of the country. CC3 further stated that Staff D had stated that they were nurse delegated.

Review of fax received by the department on 04/30/2024 at 7:28 AM from CC2 showed, "Nurse Delegation: Rescinding Delegation" dated 04/15/2024 for Resident 1, 2, 3, 4, and FR. No documentation was found on Resident 5. Further review showed CC2 rescinded delegation to the AFH, clients [residents], and nursing assistants [staff]. Additionally, the only staff name listed as delegated was Staff A. Further review of the Nurse Delegation: Rescinding Delegation showed Staff A was notified on 04/15/2024 by CC2 that they were rescinding delegation on 04/19/2024. The document showed Staff A verbalized understanding of the need to secure a new nurse delegator and understood the effective date to rescind nurse delegation was 04/19/2024.

Review of email correspondence received by the department on 04/30/2024 at 7:08 PM

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from Staff A showed, they had been out of the country from 03/10/2024-04/17/2024.

Review of email correspondence received by the department on 05/07/2024 at 2:13 PM from Staff A, showed a forwarded email dated 04/22/2024 at 12:24 PM from Staff A to Resident 2's Department Case Manager (DCM). Further review showed Staff A requested a new nurse delegator in this email.

Resident 1

On 4/23/2024 at 10:42 AM, Resident 1 stated that Staff C assisted them with their medications since they moved into the AFH. Resident 1 said they took medications to control their high blood pressure and cholesterol levels. Resident 1 added that they were not sure if they received the right dosage of their pain pills and medications for muscle spasms because they were still getting headaches and muscle pain.

04/24/2024 at 3:49 PM, observation showed Resident 1 had old scars to bilateral (both) lower legs. Observation also showed the skin was dry and flaky. Observation showed long toenails that were thick and brittle.

In an interview on 04/24/2024 at 3:52 PM, Staff A stated that they applied "A&D" lotion to Resident 1's legs daily after bathing.

Review of email correspondence received by the department on 05/05/2024 at 8:14 PM from Staff A showed, Resident 1 was admitted to the AFH on [REDACTED]/2024.

Review of Resident 1's Initial Assessment dated [REDACTED]/2024 showed Resident 1 required medication assistance from the AFH. Further review showed Resident 1 had poor coordination and was unable to read/see labels. Further review showed Resident 1 required nurse delegation for wound and skin care. Further review of Resident 1's records showed no NCP.

Review of Resident 1's March 2024 pharmacy-generated Medication Administration Record (MAR) and Resident 1's April 2024 handwritten MAR showed, check marked entries instead of staff initials, there was no documentation as to which staff had provided Resident 1 with medication.

In a phone interview on 05/09/2024 at 2:37 PM, CC2 stated that they had received a referral for a nurse delegation for Resident 1. CC2 further stated that they had called the AFH and were told that Resident 1 was currently hospitalized. Additionally, CC2 stated that the AFH never followed up to arrange delegation for Resident 1. CC2 stated that they had provided a notice of rescinding delegation for Resident 1 as they were rescinding delegation of the facility and all residents.

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Review of Comprehensive Assessment Reporting and Evaluation (CARE) showed a Service Episode Record (SER) note dated 03/18/2024 that Resident 1 was scheduled to be admitted to the AFH on 03/19/2024. Further review showed the admission had been delayed due to Resident 1's illness. Review of SER note dated [REDACTED]/2024 showed Resident 1 was admitted to the AFH on [REDACTED]/2024.

In email correspondence received by the department on 05/10/2024 at 10:30 AM, Staff A had stated that, Resident 1 did not require nurse delegation.

In a phone interview on 05/10/2024 at 3:13 PM, Collateral Contact 4 (CC4) stated that Resident 1 was prescribed Bisacodyl 10 mg suppository, unwrap and insert 1 suppository rectally daily as needed for constipation if no bowel movement in 24 hours.

Review of Resident 1's March 2024 and April 2024 pharmacy-generated MAR showed Resident 1 was prescribed, Bisacodyl 10 mg suppository, unwrap and insert 1 suppository rectally daily as needed for constipation if no bowel movement in 24 hours. There were no nurse delegation documents showing Staff C, D and E had been delegated to administer suppositories.

Resident 2

(Resident aware self manage, ask help he needs)
He

Review of CARE showed Resident 2's Current Assessment dated 06/07/2023. Further review showed Resident 2 required nurse delegation for crushed medication and the application of topical medications.

Now He is out since [REDACTED] 2024

Review of Resident 2's Resident Intake and NCP dated 04/20/2023 showed Resident 2 was admitted to the AFH on [REDACTED]/2020. Further review showed Resident 2 required nurse delegation for the following: crushed medication, Foley Catheter (a rubber tubing inserted through the urethra into the bladder to drain urine) that helps drain urine from the bladder) care, insulin (used to treat high blood sugar) dosing, and Diabetic (a medical condition that causes high blood sugar) monitoring.

He don't have Foley catheter now

Review of fax received by the department on 05/09/2024 at 2:29 PM from CC2 showed, Nurse Delegation: Nursing Visit dated 04/06/2023 was the initial assessment for nurse delegation for Resident 2. Further review showed Resident 2 required nurse delegation for the administration of, oral and topical medications, eye drops, blood glucose (measures the level of sugar in the blood) checks, and administration of insulin. Further review showed Nurse Delegation: Nursing Visit dated [REDACTED]/2024 was a supervisory visit that showed Resident 2 required nurse delegation for the same tasks as documented 04/06/2023. In addition, Staff A was the only staff name listed as being nurse delegated for Resident 2.

A review of AFH records showed there were no nurse delegation documents showing Staff

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C, D and E had been delegated to administer medications and provide nursing tasks for Resident 2.

Resident 3

On 04/24/2024 at 3:25 PM, observation showed Resident 3 had swelling to bilateral lower legs with right lower leg more swollen than the left leg. Resident 3 had dry skin to bilateral lower legs with foul odor.

On 04/24/2024 at 3:26 PM, Resident 3 stated that they did not have any open wounds and refused a skin assessment.

Review of CARE showed Resident 3's Current Annual Assessment dated 06/30/2023. Further review showed Resident 3 required assistance with medication at resident's request. Additionally, Resident 3's Assessment showed they required application of ointments and lotions.

Review of Resident 3's NCP dated 01/03/2020 and reviewed on 10/11/2023 showed Resident 3 was admitted to the AFH on [REDACTED]/2019. Further review of Resident 3's NCP showed Resident 3 required nurse delegation for inhaler (medication inhaled through the mouth) and topical medication.

Review of fax received by the department on 05/09/2024 at 2:29 PM from CC2 showed, Nurse Delegation: Nursing Visit dated 03/15/2024 showed Resident 3 required nurse delegation for the administration of oral, topical, and inhalant medication, nasal spray (inhaled through the nose), blood glucose checks (checks the amount of sugar in a drop of blood), and administration of insulin. In addition, Staff A was the only staff listed as being nurse delegated.

A review of AFH records showed there were no nurse delegation documents showing Staff C, D and E had been delegated to administer medications and provide nursing tasks for Resident 3.

Resident 4

On 04/24/2024 at 3:28 PM, observation showed Resident 4 had scars to bilateral lower legs. Right foot had scaling in between the toes. In between the toes of both feet were moist with a foul odor. Resident 3 declined a full skin assessment. When interviewed, Resident 4 stated that they had a urostomy (an opening in the abdomen that allows urine to leave body) and refused observation.

On 04/24/2024 at 3:32 PM, Staff A was asked how often the skin assessment was performed

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on Resident 4, and Staff A stated that Resident 4 had a home health nurse conducted visits. When asked about reports from the home health nurse visit, Staff A stated that they did not have any.

Review of CARE showed Resident 4's Current Annual Assessment dated 01/02/2024. Further review showed Resident 4 required assistance with medication at resident's request. Additionally, Resident 4's Assessment further showed that they required nurse delegation for inhaler, cream, ointment, and as needed (PRN) pain patch.

Review of Resident 4's Resident Intake and NCP dated 04/20/2023 showed Resident 4 was admitted to the AFH on [REDACTED]/2020. Further review showed Resident 4 required nurse delegation for Foley catheter care, Diabetic monitoring, and insulin (liquid solution injected into fat under skin to control high blood sugar) administration.

Review of fax received by the department on 05/09/2024 at 2:29 PM from CC2 showed, Nurse Delegation: Nursing Visit dated [REDACTED] 2024 showed Resident 4 required nurse delegation for the administration of oral, topical, and inhalant medication, administration of insulin and non-insulin diabetes injection, application of medicated patch, and blood glucose checks. In addition, Staff A was the only staff listed as being nurse delegated.

A review of AFH records showed there were no nurse delegation documents showing Staff C, D and E had been delegated to administer medications and provide nursing tasks for Resident 4.

[REDACTED]
Former Resident (FR)

Review of CARE showed FR's Interim Assessment dated 12/06/2023 showed FR required medication administration and nurse delegation for medication, ostomy (surgically created opening in the abdomen that allows waste to leave the body) care, lotion, and ointment.

Review of FR's NCP dated 06/20/2023 showed FR was admitted to the AFH on [REDACTED]/2023. Further review of FR's NCP showed they required nurse delegation for medication administration and topical medication.

Review of fax received by the department on 05/09/2024 at 2:29 PM from CC2 showed, Nurse Delegation: Nursing Visit dated 03/15/2024 showed FR required nurse delegation for the administration of oral and topical medication, foley catheter care, bladder irrigation, and colostomy (surgical opening in the abdomen that allows feces to exit the body) care. In addition, Staff A was the only staff listed as being nurse delegated.

In an interview on 05/08/2024 at 8:12 AM, Collateral Contact 1 (CC1) stated that FR had been admitted to a local health facility on [REDACTED]/2024 and would not be returning to the AFH. CC1 further stated that staff had not been trained to properly care for FR's wounds

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and to provide medication. Additionally, CC1 stated that new staff had been hired while Staff A was out of the country, and they had not been properly trained to care for the residents.

A review of AFH records showed there were no nurse delegation documents showing Staff C, D and E had been delegated to administer medications and provide nursing tasks for FR.

Resident 5

On 04/24/2024 at 3:36 PM, observation showed Resident 5 had redness to the side of the neck and an open area to the right ear that stretched towards the back of the neck. Observation showed Resident 5 also had a scab to the right big toe with brown discoloration. Further observation showed other toes on both feet were brittle and thick nails with brown discoloration. Observed left foot had open areas in between first and second toe with yellow-green drainage and a dry scab on the left big toe.

On 04/24/2024 at 3:37 PM, Staff A stated that they first noted the redness to the neck and open area to the right ear on 04/19/2024. When questioned further, Staff A stated that they notified the physician and had not received a reply. Staff A also stated that the wounds to the left toes were new, and they had no idea of how they happened.

Review of Resident 5's "Assessment Care Plan" dated 11/24/2023 showed Resident 5 was diagnosed with [REDACTED].

Further review of Resident 5's Assessment Care Plan showed Resident 5 could not ask appropriately for PRN medication and required nurse delegation.

Review of Resident 5's NCP dated 12/12/2023 showed Resident 5 was admitted to the AFH on [REDACTED]/2023. Further review showed Resident 5 required nurse delegation for topical medication.

Review of email correspondence received by the department on 05/09/2024 at 2:02 PM from CC2 showed, they did not have a referral for nurse delegation for Resident 5. Review further showed CC2 was not notified of Resident 5's admission to the AFH.

In an email correspondence received by the department on 05/10/2024 at 10:30 AM, Staff A stated that, Resident 5 did not require nurse delegation.

In a phone interview on 05/10/2024 at 3:13 PM, CC4 stated that Resident 5 was prescribed the following PRN medication.

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-Baza Protect Moisture Cream, apply topically to affected area(s) of the bilateral (both sides) buttocks twice daily.

- "Hydrocodone-Acetamin" 5-325 milligram (mg), take 1 tablet by mouth every 6 hours as needed for pain.

-Thera-derm lotion, apply topically on both legs twice daily.

-Acetaminophen 325 mg, take 2 tablets (650 mg) by mouth every 6 hours as needed for pain/fever/headache.

-Calcium Antacid 750 mg, chew and swallow 1 tablet by mouth every 6 hours as needed for stomach discomfort.

-Diclofenac Sodium 1 percent (%), apply 4 grams topically 4 times daily as needed for knee pain.

-Loperamide 2 mg, take 2 capsules (4 mg) by mouth as needed after first diarrhea episode. Then take 1 capsule by mouth after each loose stool.

- "Mucus Relief ER" 600 mg, take 1 tablet by mouth twice daily as needed for nasal congestion and cough.

- "Ondansetron HCL" 4 mg, take 1 tablet by mouth every six hours as needed for nausea/vomiting.

-Nyamyc 100,000 units/gram, apply topically to affected area(s) of the skin folds and groin areas twice daily as needed for rash/redness.

Review of Resident 5's April 2024 AFH computer-generated MAR, found in the AFH on 04/23/2024, showed Resident 5 was prescribed, Baza Protect Moisture Cream, "Hydrocodone-Acetamin" 5-325 mg, Thera-derm lotion, Acetaminophen 325 mg, Calcium Antacid 750 mg, Diclofenac Sodium 1%, Loperamide 2mg, "Mucus Relief ER" 600 mg, "Ondansetron HCL" 4 mg, and Nyamyc 100,000 units/gram.

Further review of Resident 5's April 2024 AFH computer-generated MAR showed, check marked entries instead of staff initials when medications were administered. There was no documentation as to which staff had provided Resident 5 with their medication. In addition, Resident 5's AFH computer-generated MAR showed a handwritten entry for

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"Tamsulitin[sic] HCL" 0.4 mg, 8AM and "Gebapentin[sic]" 100 mg, 8:00 AM, 2:00 PM, and 8:00 PM. The handwritten entries for both medications, were written on a blank area on the MAR that did not include rows or any boxes for staff to initial when medication had been provided to Resident 5. Resident 5's April 2024 AFH computer-generated MAR showed no check mark for "Gebapentin[sic]" 2:00 PM dose on 04/06/2024, 04/08/2024, 04/10/2024, 04/16/2024, 04/21/2024, and 04/22/2024. There were no check marked entries for "Gebapentin[sic]" 100 mg for the 8:00 PM dose on 04/07/2024 and 04/22/2024.

A further review of AFH records showed there were no nurse delegation documents showing Staff A, C, D and E had been delegated to administer medications or nursing tasks to Resident 5.

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, Senior Best Care Inc. is or will be in compliance with this law and / or regulation on (Date) 05-04-2024

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


Provider (or Representative)

06/10/24
Date

WAC 388-76-10198 Adult family home Personnel records. The adult family home must keep documents related to staff in a place readily accessible to authorized department staff. These documents must be available during the staff's employment, and for at least two years following employment. The documents must include but are not limited to:

- (3) Tuberculosis testing results.
- (4) Criminal history disclosure and background check results as required.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure 3 of 5 staff (Staff A, Entity Representative/Resident Manager, Staff D, Caregiver, and Staff E, Caregiver) had staff records readily accessible to Department Staff. This failure delayed the Department from determining if Staff A, Staff D, and Staff E were qualified to care for the AFH's 4 of 5 current residents.

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Findings included...

During a visit on 04/23/2024 at 10:04 AM, observation showed Residents 1, 3, 4, and 5 lived in and received care from the AFH. Further observation showed Resident 2 was not in the AFH. Additionally, observation showed Staff A worked in the AFH and provided care to the residents.

In an interview on 04/23/2024 at 10:12 AM, Staff A stated that Resident 2 had been admitted to a local health facility for scheduled surgery on [REDACTED]/2024 and would be returning to the AFH soon.

Staff A

Review of Staff A's personnel records showed the AFH was licensed on 03/06/2018. Further review showed Staff A had a fingerprint background check completed on 02/03/2015. Additionally, review showed Staff A's fingerprint result indicated there was a non-disqualifying finding that required the completion of a character, competence, and suitability review.

In an interview on 04/23/2024 at 4:06 PM, Staff A stated that they did not have a character, competence, and suitability review. Staff A further stated that they did not know what it was. Department Staff explained what the character, competence, and suitability review was and why it was required.

In an interview on 04/23/2024 at 4:10 PM, Staff A stated that they would complete the character, competence, and suitability review form and send it to the department.

As of 05/15/2024, Staff A's character, competence, and suitability review has not been received by the department.

Staff D

Review of Staff D's records showed no date of hire. Further review showed no Tuberculosis [(TB), a bacterial infection that affects the lungs and can be fatal without treatment], test records for Staff D.

In an interview on 04/23/2024 at 5:04 PM, Staff A stated that Staff D's date of hire was 02/07/2024. Staff A further stated that they did not have a copy of Staff D's TB Test results and would send them to the department.

Staff E

Review of Staff E's records showed a hire date of 03/07/2024. Further review showed no TB test records for Staff E.

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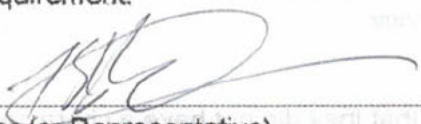
In an interview on 04/23/2024 at 5:07 PM, Staff A stated that they could not locate a copy of Staff E's TB test results and would send them to the department.

This is a repeated deficiency cited on 02/28/2024 for subsections (2)(3)(4).

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, Senior Best Care Inc. is or will be in compliance with this law and / or regulation on (Date) 05/10/24.

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


Provider (or Representative)

6/10/24
Date

WAC 388-76-10225 Reporting requirement.

(4) The adult family home must notify the department's case management office within twenty-four hours whenever a resident, whose stay is paid for by the department is discharged for more than twenty-four hours on medical leave to a nursing home or hospital.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to notify the Department Case Manager (DCM) for 1 of 5 residents (Resident 2) admitted to a Local Health Facility (LHF) for more than 24 hours. This failure placed Resident 2 at risk for post discharge care coordination problems and potential overpayment from the Department.

Findings included...

During a visit on 04/23/2024 at 10:04 AM, observation showed Resident 2 was not present in the AFH.

In an interview on 04/23/2024 at 10:12 AM, Staff A, Entity Representative/Resident Manager, stated that Resident 2 had been admitted to a LHF for scheduled surgery on [REDACTED]/2024 and would be returning to the AFH soon.

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A Review of Resident 2's "Pre-Procedure instructions" dated, 02/07/2024 showed Resident 2 was scheduled for surgery on [REDACTED]/2024.

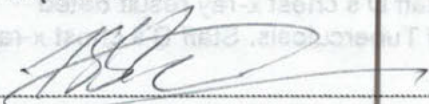
Review of email correspondence received by the department on 05/07/2024 at 2:13 PM from Staff A, showed a forwarded email dated 04/22/2024 at 12:24 PM from Staff A to Resident 2's DCM. Further review showed Staff A notified Resident 2's DCM on 04/22/2024 at 12:24 PM of Resident 2's surgery and hospitalization, [REDACTED] beyond the 24-hour period of notification.

This is a repeated deficiency cited on 02/02/2023.

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, Senior Best Care Inc. is or will be in compliance with this law and / or regulation on (Date) 5/9/24.

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


Provider (or Representative)

06/10/24
Date

WAC 388-76-10290 Tuberculosis Positive test result. When there is a positive result to tuberculosis skin or blood testing the adult family home must:

- (1) Ensure that the person has a chest X-ray within seven days;

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 5 staff (Staff D, Caregiver) had a chest x-ray or blood testing completed within seven days after a positive Tuberculosis [(TB), a bacterial infection that affects the lungs and can be fatal without treatment], skin test result. This failure placed all residents and staff in the AFH at risk of illness in the event Staff D had TB, a communicable disease affecting the lungs.

Findings included...

During a visit on 04/23/2024 at 10:04 AM, observation showed Residents 1, 3, 4, and 5 present in the home, and received care from the AFH. Further observation showed Resident 2 was not in the AFH. Additionally, observation showed Staff A, Entity

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Representative/Resident Manager, and Staff C, Caregiver, worked in the AFH and provided care to the residents.

was temporary for few days

Review of Staff D's records showed no date of hire. Further review showed no TB test records for Staff D.

In an interview on 04/23/2024 at 5:04 PM, Staff A stated that Staff D's date of hire was 02/07/2024. Staff A further stated that they did not have a copy of Staff D's TB Test results and would send them to the department.

Review of an email correspondence received by the department on 04/25/2024 at 10:43 PM from Staff A, showed a positive TB skin test result dated 03/08/2024 for Staff D. Further review showed a positive TB skin test result and recommendation for further testing for Staff D.

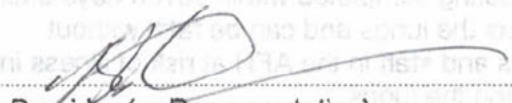
In a follow-up phone interview on 04/29/2024 at 1:52 PM, Staff A stated that Staff D had no symptoms of TB. Staff A further stated that they would send Staff D for a blood test or an x-ray the following day.

In an email correspondence received by the department on 05/01/2024 at 11:56 AM from Staff A showed a copy of Staff D's chest x-ray result. Review of Staff D's chest x-ray result dated 05/01/2024 at 9:37 AM showed Staff D had no evidence of Tuberculosis. Staff D's chest x-ray was completed 47 days beyond the 1-week requirement.

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, Senior Best Care Inc. is or will be in compliance with this law and / or regulation on (Date) 05/01/24.

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


Provider (or Representative)

06/16/24
Date

WAC 388-76-10360 Negotiated care plan Timing of development Required. The adult family home must ensure the negotiated care plan is developed and completed within thirty days of the resident's admission.

This requirement was not met as evidenced by:

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Based on observation, interview, and record review, the Adult Family Home (AFH) failed to develop a Negotiated Care Plan (NCP) for 1 of 1 residents (Resident 1) within thirty days of the resident's admission. This failure placed Resident 1 at risk of unmet care needs.

Findings included...

*gorgarized hrs medication before
left canby 10/6/24*

During a visit on 04/23/2024 at 10:04 AM, observation showed Resident 1 lived in and received care from the AFH.

Review of Comprehensive Assessment Reporting and Evaluation (CARE) showed a Service Episode Record (SER) note dated 03/18/2024 that Resident 1 was scheduled to be admitted to the AFH on 03/19/2024. Further review showed the admission had been delayed due to Resident 1's illness. Review of SER note dated [REDACTED] 2024 showed Resident 1 was admitted to the AFH on [REDACTED]/2024.

A review of Resident 1's records showed an Initial Assessment dated [REDACTED] 2024. Further review showed there was no NCP with Resident 1's records.

In an interview on 04/23/2024 at 11:15 AM, Staff A, Entity Representative/Resident Manager, stated that Resident 1 did not have an NCP.

This is a repeated deficiency cited on 01/09/2023.

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, Senior Best Care Inc. is or will be in compliance with this law and / or regulation on (Date) 05/01/24.

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

Provider (or Representative)

Date

WAC 388-76-10470 Medication Timing Special directions.

(2) The home must ensure all directions given by the practitioner are followed when assisting or giving each resident medication. This includes but is not limited to:

(a) Before meals;

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- (b) After meals;
- (c) With or without food; and
- (d) At bed time.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure physician orders were followed for 1 of 5 residents (Resident 2). This failure placed Resident 2 at risk for negative outcomes and worsening condition from not receiving medication as ordered.

Findings included...

Res 2 is aware he able to go and talk to doctor

During a visit on 04/23/2024 at 10:04 AM, observation showed Resident 2 was not present in the AFH.

In an interview on 04/23/2024 at 10:12 AM, Staff A, Entity Representative/Resident Manager, stated that Resident 2 had been admitted to a local health facility for scheduled surgery on [REDACTED]/2024 and would be returning to the AFH soon.

In an interview on 04/23/2024 at 11:46 AM, Staff A stated that Resident 2's physician had instructed not to give Resident 2 medication on 03/14/2024.

A review of Resident 2's Pre-Procedure Instructions, dated 02/07/2024 for surgery on [REDACTED]/2024 showed Resident 2 medication recommendations were as follows:

-Stop taking nonsteroidal anti-inflammatory medications such as Ibuprofen (Advil, Motrin), Naproxen (Aleve), Diclofenac, Ketorolac (Toradol) 7 days prior to surgery.

-Stop fish oil, omega3-fatty acids, and other supplements 7 days prior to surgery. A review of Resident 2's March 2024 computer-generated MAR showed they were prescribed, Ascorbic Acid 500 mg, (Vitamin C), take 1 tablet on Monday/Wednesday/Friday mornings for anemia. Resident 2's MAR showed a check marked entry for the 8:00 AM dose on [REDACTED]/2024 and [REDACTED]/2024. Ferrous Sulfate 325 mg, take 1 tablet by mouth on Monday/Wednesday/Friday for anemia. Resident 2's March 2024 computer-generated MAR showed a check mark entry for the 8:00 AM dose on [REDACTED]/2024.

-Stop taking Eliquis 2 days prior to surgery (last dose on [REDACTED]/2024). Resident 2's March 2024 computer-generated MAR showed a check marked entry for the 6:00 AM and 6:00 PM dose on [REDACTED]/2024 and a check marked entry for the 6:00 AM dose on [REDACTED]/2024.

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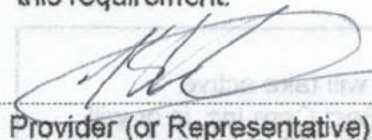
-The night before surgery please take Insulin Glargine 10 unit (2/3 usual dose). Resident 2's March 2024 computer-generated MAR showed no documentation for the 8:00 PM dose on [REDACTED]/2024. In addition, there was no documentation of a change in dosage for Resident 2's Insulin Glargine for the 8:00 PM dose on [REDACTED] 2024.

He did and follow instruction as given by doctor he has doctor in his room.

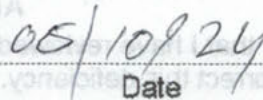
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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Senior Best Care Inc. is or will be in compliance with this law and / or regulation on (Date) 04/23/24.

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



Provider (or Representative)



Date

WAC 388-76-10485 Medication storage. The adult family home must ensure all prescribed and over-the-counter medications are stored:

(2) In the original container with legible and original labels; 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 1) had a legible medication label on a bottle of medication. This failure placed Resident 1 at risk of medication errors and of potentially taking an expired medication.

Findings included...

During a visit on 04/23/2024 at 10:04 AM, observation showed Resident 1 lived in and received medication assistance from the AFH.

Observation on 04/23/2024 at 10:42 AM, showed Resident 1's bedside table had a small brown bottle that contained about 10 pills. Further observation showed the medication label had been peeled off the bottle. Additionally, there was no indication of who the medication was for, the name of the medication, dosage, frequency, or expiration date.

In an interview on 04/23/2024 at 10:43 AM, Resident 1 stated that the small brown bottle contained Nitroglycerin (for chest pain). Resident 1 further stated that if they had chest pain, they did not want to delay, waiting for staff to respond to their call bell. Additionally,

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Resident 1 stated that they would use the Nitroglycerin instead which they kept on their bedside table.

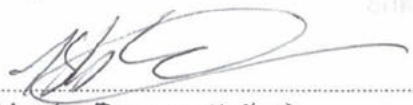
A review of Resident 1's records showed 3 different April 2024 Medication Administration Records (MAR); a handwritten MAR, a pharmacy-generated MAR, and a computer-generated MAR. In addition, there was no entry for Nitroglycerin on any of Resident 1's April 2024 MAR's.

In an interview on 04/23/2024 at 6:46 PM, Staff A, Entity Representative/Resident Manager stated that Resident 1's Nitroglycerin was not on Resident 1's MAR. Staff A further stated that Resident 1's Nitroglycerin was old, and that Resident 1 had not notified their physician that they had been using the medication.

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Provider (or Representative)

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Date

WAC 388-76-10490 Medication disposal Written policy Required. The adult family home must have and implement a written policy addressing the disposal of unused or expired resident medications. Unused and expired medication must be disposed of in a safe manner for:

- (1) Current residents living in the adult family home; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to implement their medication disposal policy for 2 of 5 residents (Resident 1 and Resident 2). This failure placed Resident 1 and Resident 2 at risk for side effects or decreased action from taking an expired medication.

Findings included...

During a visit on 04/23/2024 at 10:04 AM, observation showed Resident 1 lived in and received medication assistance from the AFH. Further observation showed Resident 2 was

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not present in the AFH. In addition, Staff A, Entity Representative/Resident Manager, and Staff C, Caregiver, worked in the AFH and provided care to the residents.

In an interview on 04/23/2024 at 10:12 AM, Staff A stated that Resident 2 had been admitted to a local health facility for scheduled surgery on [REDACTED]/2024 and would be returning to the AFH soon.

Resident 2

On 04/23/2024 at 10:23 AM, observation showed one unopened box of Lispro (Admelog) Insulin 100 units for Resident 2 in the kitchen refrigerator. This was labelled inject 20 units subcutaneously 3 times daily with meals for high blood sugar. Further observation showed the Lispro (Admelog) Insulin (liquid solution injected into fat under skin to control high blood sugar) 100 units, expired 03/17/2024.

In an interview on 04/23/2024 at 10:24 AM, Staff A stated that they did not know Resident 2's Lispro (Admelog) Insulin, 100 units had expired.

On 04/23/2024 at 10:54 AM, observation showed "Ondansetron ODT" 8 milligrams (mg), dissolve 1 by mouth every six hours as needed for nausea, in Resident 2's medication storage container. Further observation showed Resident 2's "Ondansetron ODT" 8 mg, expired on 03/13/2024.

In an interview on 04/23/2024 at 10:56 AM, Staff A stated that they were not aware Resident 2's "Ondansetron ODT" 8 mg had expired.

Resident 1

On 04/23/2024 at 10:42 AM, observation showed Resident 1's bedside table had an Albuterol inhaler (increases airflow to the lungs), that expired in February 2018.

In an interview on 04/23/2024 at 6:45 PM, Staff A stated that they were not aware an Albuterol Inhaler was on Resident 1's bedside table or that it had expired.

Review of the AFH's undated "Medication Disposal Form/Policy" showed medications were disposed by mixing with coffee grounds, kitty litter, or with the RX Destroyer (chemical destruction container that converts solid and liquid medications into a non-retrievable form).

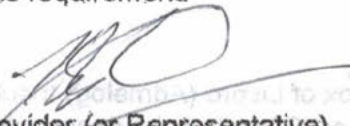
This is a repeated deficiency cited on 02/28/2024 for subsection (1).

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


Provider (or Representative)

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Date

WAC 388-76-10750 Safety and maintenance. The adult family home must:

(1) Keep the home both internally and externally in good repair and condition with a safe, comfortable, sanitary, and homelike environment that is free of hazards;

This requirement was not met as evidenced by:

Based on observation and interview, the Adult Family Home (AFH) failed to ensure the home was kept in good repair with a sanitary homelike environment. These failures placed residents at risk of invasion of privacy and cockroaches in the kitchen.

Findings included...

During a visit on 04/23/2024 at 10:04 AM, observation showed Residents 1, 3, 4, and 5 present in the home, and received care from the AFH.

On 04/23/2024 at 10:30 AM, observation showed a brown sticky substance and crumbs in the lower kitchen cabinets, where the pots and pans were kept. Observation further showed the utensil drawer had crumbs, hair, and was sticky around the utensil tray.

On 04/23/2024 at 10:33 AM, observation showed Bedroom B, used by Staff C, Caregiver, had no bathroom door.

On 04/23/2024 at 10:37 AM, observation showed Bedroom [REDACTED], currently vacant due to Former Resident (FR) discharging on [REDACTED]/2024, had no bathroom door.

In an interview on 04/23/2024 at 10:38 AM, Staff A, Entity Representative/Resident Manager stated that they would be installing bathroom doors.

This is a repeated deficiency cited on 02/28/2024 for subsection (1).

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06/10/24
Date

WAC 388-76-10855 Emergency and disaster plan training Required. The adult family home must ensure all staff are trained on the emergency and disaster plan and procedures when they begin work in the home and all staff and residents review the emergency and disaster plan and procedures at least annually.

This requirement was not met as evidenced by:

Based on observation and interview, the Adult Family Home (AFH) failed to ensure 1 of 1 staff (Staff C, Caregiver) had been trained on the emergency and disaster plan. This failure placed all residents at risk of serious injury in the event of an emergency requiring evacuation from the AFH.

Findings included...

During a visit on 04/23/2024 at 10:04 AM, observation showed Residents 1, 3, 4, and 5 present in the home, and received care from the AFH staff. Further observation showed Staff A, Entity Representative/Resident Manager, and Staff C worked in and provided care to the residents.

In an interview on 04/23/2024 at 4:43 PM, Staff C stated that they had never completed an emergency evacuation drill in the AFH.

In an interview on 04/23/2024 at 4:44 PM, Staff A stated that Staff C had completed an emergency evacuation drills somewhere else. Department Staff (DS) informed Staff A and Staff C that the AFH needed to conduct a full emergency evacuation drill, that required staff to evacuate all four residents to the meeting place outside the home in 5 minutes or less.

On 04/23/2024 at 4:46 PM observation showed the full emergency evacuation drill had begun.

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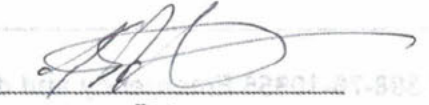
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On 04/23/2024 at 4:48 PM Staff C asked DS what they were supposed to do. DS redirected Staff C to speak with Staff A.

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Provider (or Representative)
Date06/10/24