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

Cherished Acres

Cherished Acres
6204 S 296th St
Auburn, WA 98001

RE: Cherished Acres License # 753629

Dear Provider:

This letter addresses Compliance Determination(s) 46740 (Completion Date 08/29/2024) and 45315 (Completion Date 08/09/2024).

The Department completed a follow-up inspection of your Adult Family Home on 08/29/2024 and found that you have corrected the violations listed in the Full report dated 08/09/2024. Your home is back in compliance as of 08/09/2024 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 388-76-10455-2

The Department staff who did the on-site verification:
Olga Petrov, NCI

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 #: 753629	Compliance Determination # 45315
Plan of Correction	Cherished Acres	Completion Date
Page 1 of 6	Licensee: Cherished Acres	08/09/2024

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 the unannounced on-site full inspection on 08/05/2024 and 08/05/2024 of:
Cherished Acres
37612 165th Ave SE
Auburn, WA 98092

The following sample was selected for review during the unannounced on-site visit: 2 of 3 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Olga Petrov, 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 — Date: 08/24/2024

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

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 08/05/2024 and 08/05/2024 of:

Cherished Acres
37612 165th Ave SE
Auburn, WA 98092

The following sample was selected for review during the unannounced on-site visit: 2 of 3 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Olga Petrov, 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

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) 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.

This requirement was not met as evidenced by:

Based on observation, interview and record review the Adult Family Home (AFH) failed to ensure a medication system was in place to ensure they followed recommended guidelines when they assisted 2 of 2 sampled resident's (Resident 1 and 2) with their medications as required. Additionally, they failed to ensure that 4 of 4 caregivers (Staff B, Resident Manager, Staff C, Caregiver, Staff D, Caregiver and Staff E, Caregiver) initialed medication logs to attest they administered medications and did not initialed medication logs if they did not administer medications. These failures placed Residents 1 and 2 at risk of harm from medication errors.

Findings included...

Observation on 08/05/2024 at 8:34 AM, showed Resident 1 was in their dining chair and Resident 2 was in their Wheelchair (WC) at the dining table with breakfast in front of them. Observation showed there were medications in the transparent plastic cups on the dining trays in front of Resident 1 and 2. There were no names and/or residents' identifiers on the medication's cups. Staff D transferred the resident's medications from the plastic cup into spoon and spoon fed them to Resident 2. Staff D, then, spoon fed breakfast to Resident 2 at the dining table.

Observation on 08/05/2024 at 8:41 AM, showed Staff E transferred medications from a plastic cup into a spoon and spoon fed them to Resident 1.

Observation on 08/05/2024 at 8:43 AM, showed Resident 1 ate their breakfast by themself at the dining table.

In an interview on 08/05/2024 at 9:35 AM, Staff B stated that Residents 1 and 2 required administration of their medications.

Resident 1

Provider (or Representative) 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.

This requirement was not met as evidenced by:

Based on observation, interview and record review the Adult Family Home (AFH) failed to ensure a medication system was in place to ensure they followed recommended guidelines when they assisted 2 of 2 sampled resident's (Resident 1 and 2) with their medications as required. Additionally, they failed to ensure that 4 of 4 caregivers (Staff B, Resident Manager, Staff C, Caregiver, Staff D, Caregiver and Staff E, Caregiver) initialed medication logs to attest they administered medications and did not initialed medication logs if they did not administer medications. These failures placed Residents 1 and 2 at risk of harm from medication errors.

Findings included…

Observation on 08/05/2024 at 8:34 AM, showed Resident 1 was in their dining chair and Resident 2 was in their Wheelchair (WC) at the dining table with breakfast in front of them. Observation showed there were medications in the transparent plastic cups on the dining trays in front of Resident 1 and 2. There were no names and/or residents' identifiers on the medication's cups. Staff D transferred the resident's medications from the plastic cup into spoon and spoon fed them to Resident 2. Staff D, then, spoon fed breakfast to Resident 2 at the dining table.

Observation on 08/05/2024 at 8:41 AM, showed Staff E transferred medications from a plastic cup into a spoon and spoon fed them to Resident 1.

Observation on 08/05/2024 at 8:43 AM, showed Resident 1 ate their breakfast by themself at the dining table.

In an interview on 08/05/2024 at 9:35 AM, Staff B stated that Residents 1 and 2 required administration of their medications.

Resident 1

Resident 1's record review showed the resident's assessment dated 02/08/2024 and negotiated care plan dated 02/15/2024, showed the resident required crushing and administration of their medications.

Review July 2024 Resident 1' s medication log showed that Resident 1 was on complex medication management. Further review showed that on 08/05/2024's (day of the inspection) Resident 1's ten of twelve morning medications were signed as given by Staff B and two of twelve morning medications were signed as given by Staff C. Staff B and C were not a caregiver who administered morning medications to Resident 1 on 08/05/2024. Staff D administered morning medications to Resident 1 on 08/05/2024.

Resident 2

Resident 2's record review showed the resident's assessment dated 11/28/2023 and negotiated care plan dated 12/28/2023, showed the resident required administration of their medications due to their confusion.

Review of July 2024 Resident 2' s medication log showed that Resident 2 was on complex medication management. Further review showed that on 08/05/2024's (day of the inspection) Resident 2's nine out of ten morning medications were signed as given by Staff B and one out of ten morning medications were signed as given by Staff C. Staff B and C were not caregivers who administered morning medications to Resident 2 on 08/05/2024. Staff E administered morning medications to Resident 2 on 08/05/2024.

In an interview on 08/05/2024 at 12:05 PM, when asked who prepared Resident 1 and 2' s morning medications, Staff C stated that Staff F, Caregiver prepared Resident 1 and 2' s medications that morning. Staff C stated that Staff F placed the residents' medications from the bubble packs into plastic medication cups and left them in front of the residents' medication baskets in the medication cabinet prior to leaving to another AFH. Staff C stated that they (Staff C) took the cups, with prepared Resident 1 and 2's medications from the medication cabinets and placed them on the dining trays with prepared breakfast. Staff C stated that Staff C placed the trays in front of the Resident 1 and 2 at the dining table. Staff C stated that Staff E spoon fed medications from the cup to Resident 1 and Staff D spoon fed medications to Resident 2 at the dining table.

On phone interview on 08/06/2024 at 3:37 PM, after reviewing Resident 1 and 2's July 2024 MARS, when asked if Staff B prepared and administered morning medications to Resident 1 and 2 on 08/05/2024, Staff B stated that they did not prepare and/or administer medications to the residents. Staff B stated that Staff C initialed Resident 1 and 2's morning medications on 08/05/2024 as given by using Staff B's initials.

In an interview on 08/05/2024 at 12:35 PM, when asked why Resident 1 and 2's medications were prepared by one person (Staff F), transferred by another staff (Staff

C), administered by two additional staff members (Staff D and E) and signed by Staff B, Staff B stated that caregivers were confused. When asked why the home did not follow the six rules of medication (right Patient, right medication, right dose, right route, right time, right documentation), Staff B stated they would follow the rules.

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, Cherished Acres is or will be in compliance with this law and / or regulation on (Date) 8-9-24

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

Provider (or Representative) — Date: 8-18-2024

WAC 388-76-10455 Medication Administration. For residents assessed with requiring the administration of medications, the adult family home must ensure medication administration is:

(2) By nurse delegation per WAC 246-840-910 through 246-840-970 ; unless

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to ensure 2 of 2 residents (Residents 1 and 2) who required nurse delegation for medication administration received medications from caregivers who were delegated. This failure placed the Residents 1 and 2 at risk of improper medication administration when they received medications from caregivers who were not nurse delegated.

Findings included...

Observation on 08/05/2024 at 8:34 AM, showed Resident 1 was in their dining chair and Resident 2 was in their Wheelchair (WC) at the dining table with breakfast on the dining trays in front of them. Observation showed there were medications in the transparent plastic cups on the dining trays. Staff D, Caregiver transferred the resident's medications from the plastic cup into spoon and spoon fed them to Resident 2. Staff D, then spoon fed breakfast to Resident 2 at the dining table.

Observation on 08/05/2024 at 8:41 AM, showed Staff E transferred the resident's medications from the plastic cup into spoon and spoon fed them to Resident 1.

C), administered by two additional staff members (Staff D and E) and signed by Staff B, Staff B stated that caregivers were confused. When asked why the home did not follow the six rules of medication (right Patient, right medication, right dose, right route, right time, right documentation), Staff B stated they would follow the rules.

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, Cherished Acres 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

WAC 388-76-10455 Medication Administration. For residents assessed with requiring the administration of medications, the adult family home must ensure medication administration is:

(2) By nurse delegation per WAC 246-840-910 through 246-840-970 ; unless

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to ensure 2 of 2 residents (Residents 1 and 2) who required nurse delegation for medication administration received medications from caregivers who were delegated. This failure placed the Residents 1 and 2 at risk of improper medication administration when they received medications from caregivers who were not nurse delegated.

Findings included…

Observation on 08/05/2024 at 8:34 AM, showed Resident 1 was in their dining chair and Resident 2 was in their Wheelchair (WC) at the dining table with breakfast on the dining trays in front of them. Observation showed there were medications in the transparent plastic cups on the dining trays. Staff D, Caregiver transferred the resident's medications from the plastic cup into spoon and spoon fed them to Resident 2. Staff D, then spoon fed breakfast to Resident 2 at the dining table.

Observation on 08/05/2024 at 8:41 AM, showed Staff E transferred the resident's medications from the plastic cup into spoon and spoon fed them to Resident 1.

Resident 1

Resident 1's record review showed the resident's assessment dated 02/08/2024 and negotiated care plan dated 02/15/2024, documented as having a medical history of Dementia. The resident was identified as requiring assistance with medication administration by nurse delegation.

Review of nurse delegation documentation dated 05/06/2024 revealed, Resident 1 required delegation for crushed medications, Inhaler, as needed psychotropic medications and eye drops. The resident was unable to perform these tasks independently due to "Physically unable to do for themselves." The records identified that Staff A, Entity Representative, Staff B, Staff C, Staff F and Staff G, Caregiver as being delegated for Resident 1. Staff E were not delegated for Resident 1's medications administration.

Resident 2

Resident 2's record review showed the resident's assessment dated 11/28/2023 and negotiated care plan dated 12/28/2023, documented the resident required administration of their medications due to their confusion.

Review of nurse delegation documentation dated 06/24/2024 showed, Resident 2 required delegation for medication management, oral medications and eye drops. The resident was unable to perform these tasks independently due to "cognitively unable to do for themself." The records identified the Staff A, Staff B, Staff C, Staff F and Staff G, Caregiver as being delegated for Resident 1. Staff E were not delegated for Resident 2's medications administration.

Review July 2024 Resident 2' s medication log showed that Resident 2 was on complex medication management. Further review showed that on 08/05/2024's (day of the inspection) Resident 2's nine out of ten morning medications were signed as given by Staff B and one out of ten morning medications were signed as given by Staff C. Staff B and C were not caregivers who administered morning medications to Resident 2 on 08/05/2024. Staff D administered morning medications to Resident 2 on 08/05/2024.

In an interview on 08/05/2024 at 12:15 PM, Staff B stated that Staff D and E were new hired staff, and they were not delegated for the residents' medications administration. Staff B stated that Staff D and E were confused.

Statement of Deficiencies	License #: 753629	Compliance Determination # 45315
Plan of Correction	Cherished Acres	Completion Date
Page 6 of 6	Licensee: Cherished Acres	08/09/2024

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, Cherished Acres is or will be in compliance with this law and / or regulation on (Date) 8-9-24.

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

m Amend Tam — Provider (or Representative)

8-18-2024 — Date

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, Cherished Acres 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

Plan of Correction
8/18/24
Re: Cherished Acres Statement of Deficiencies

In regards to the WAC 388-76-10430 & WAC 388-76-10455 Cherished Acres is in compliance on the date 8/09/24.

All staff members were instructed that only the Nurse Delegated staff member will administer the medication to the clients. No one else is to administer the medication or provide assistance unless they are delegated. Only the delegated caregiver/ staff will administer/ assist and sign on the MAR for the medication.

All current employees as well as delegated staff were instructed on medication management.

Provider will ensure that in the future if any new staff member were to administer/assist in medication that they will be delegated prior to handling the medication.

MOHAMMAD YASIN