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

Abiezer Adult Family Home LLC
Abiezer Adult Family Home
22422 97TH AVE W
EDMONDS, WA 98020

RE: Abiezer Adult Family Home License # 754557

Dear Provider:

This letter addresses Compliance Determination(s) 30456 (Completion Date 10/03/2023) and 28419 (Completion Date 09/05/2023).

The Department completed a follow-up inspection of your Adult Family Home on 10/03/2023 and found that you have corrected the violations listed in the Complaint report dated 09/05/2023. Your home is back in compliance as of 09/20/2023 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 388-76-10485-3, WAC 388-76-10485-1, WAC 388-76-10465-1, WAC 388-76-10465-2-c

The Department staff who did the on-site verification:
Spomenka Hodzic, NCI

If you have any questions, please contact me at (206)914-5042.

Sincerely,

Renee Bourque

Renee Bourque, Field Manager
Region 2, Unit I
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

Statement of Deficiencies	License #: 754557	Compliance Determination # 28419
Plan of Correction	Abiezer Adult Family Home	Completion Date
Page 1 of 6	Licensee: Abiezer Adult Family Home LLC	09/05/2023

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 08/22/2023 and 08/22/2023 of:

Abiezer Adult Family Home
22422 97TH AVE W
EDMONDS, WA 98020

This document references the following complaint number(s): 92979

The following sample was selected for review during the unannounced on-site visit: 3 of 5 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Spomenka Hodzic, NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit I
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.

Renee' Bourque
Residential Care Services

09/06/2023
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.

Daniel Bocktretsion
Provider (or Representative)

09/16/2023
Date

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

(1) In locked storage;

(3) Appropriately for each medication, such as if refrigeration is required for a medication and the medication is kept in refrigerator in locked storage.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Adult Family Home (AFH) failed to ensure all medications were secured in locked storage for 1 of 5 residents (Resident 1). This failure placed Resident 1 at risk for medication errors and missing medications. This failure also placed 1 of 5 residents (Resident 2) safety at risk by accessing medication not prescribed for them.

Findings included...

<Resident 1>

Record review showed the AFH admitted Resident 1 on [redacted]/2020. Resident 1's assessment, dated 04/10/2023, showed Resident 1 had significant confusion and memory impairments which affects their ability to care for themselves.

Record review of Resident 1's Negotiated Care Plan (NCP), dated on 05/02/2023, showed that Resident 1 used their feet to self-propel in the wheelchair around AFH.

<Resident 2>

Record review showed the AFH admitted Resident 2 on [redacted]/2020. Resident 2's assessment, dated 05/18/2023, showed Resident 2 required caregiver assistance to administer medications.

Record review of Resident 2's assessment, dated 05/18/2023, showed Resident 2 required caregiver assistance to administer medications.

Observation, on 08/22/2023 at 8:03 AM, showed Resident 2 in the bed in their room.

Resident 2's roommate, Resident 1, left the bedroom with Staff B, caregiver. On Resident 2s' bedside table was small plastic cup with apple sauce and multiple medications on the top.

In an interview, on 08/22/2023 at 8:05 AM, Staff A reported they were not the ones who left the medication on Resident 2's bedside table. Staff A stated that it was Staff B. Staff A stated they handed Resident 2's medications to Staff B, and Staff B left Resident 2's medications on Resident 2's bedside table because Resident 2 was still sleeping.

In an interview, on 08/22/2023 at 9:23 AM, Resident 2 stated that caregivers usually leave their morning medications on their bedside table just like they did this morning. Resident 2 stated that they take medications without anyone assisting or observing them.

Observation, on 08/28/2023 at 5:30 PM, showed Resident 1 and Resident 2 in their room in bed. Resident 2's bedside table contained a small plastic cup with one white colored tablet. AFH staff were not in Residents 1 and 2's room.

In an interview, on 08/28/2023 at 5:32 PM, Resident 2 reported that the medication in the cup was their sleeping pill. They stated that the AFH Staff left the medication for them to take around 9:00 PM.

In an interview, on 08/28/2023 at 6:16 PM, Staff D, Provider, reported that Staff A left medication on the bedside table for Resident 2 to take. Staff D reported it was Resident 2's Melatonin (medication to help with sleep). Staff D stated that they educated AFH Staff, including Staff A, not to leave medication unattended and would continue to work and train Staff A.

In an interview, on 08/28/2023 at 6:33 PM, Staff A reported that they unintentionally left Resident 2's medication on Resident 2's bedside table.

Record review of Resident 2's Medication Log (ML), dated August 2023, showed orders for Melatonin 3mg one tablet to be given at 8:00 PM.

<Resident 5>

Record review showed the AFH admitted Resident 5 on [redacted]/2020. Resident 5's assessment, dated 08/18/2022, showed Resident 5 required assistance to take their medications. Resident 5 was not able to self-administer their medications.

Record review of Resident 5's Negotiated Care Plan (NCP), dated on 10/05/2022, showed that Resident 5 was required caregiver assistance with taking their medications.

Observation on 08/22/2023 at 08:10 AM showed Resident 5 was in their room in the bed. Observation of Resident 5's bedside table showed Resident 5's prescribed eye drops, allergy nasal spray, and an inhaler (for breathing difficulties) attached to the spacer (extending attachment to give more time for medication to be inhaled).

In an interview, on 08/22/2023 at 8: 15 AM, Staff A stated that the medication on the bedside table was left by the Staff B.

In an interview, on 08/22/2023 at 8:05 AM, Staff B stated that Staff A was the one that left medication on the bedside table for Resident 5 last night.

In an interview, on 08/22/2023 at 9:38 AM, Resident 5 stated that the AFH staff left their medication on the bedside table for them, and they took their medication themselves without assistance and supervision. Resident 5 stated that they knew the AFH Staff was not supposed to leave medication by their bedside.

In an interview, on 08/22/23 at 10:25 AM, Staff D, the Provider, stated that Resident 5 was sometimes difficult to manage. Staff D reported that medications must have been left this morning at the bedside and not last night. Staff D did not have answer why the nasal spray was on the bedside table when the orders for this medication were only to be given once a day at 8:00 PM.

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, Abiezer Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 09/20/2023.

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

Daniel Rockvetsion — Provider (or Representative)

09/16/2023 — Date

WAC 388-76-10465 Medication Altering Requirements.

(1) For the purposes of this section "altering a medication" means the alteration of prescribed or over the counter medications and includes, but is not limited to crushing tablets, cutting tablets in half; opening capsules and mixing powdered medications with food or liquids.

(2) The adult family home must consult with the practitioner or pharmacist before altering a medication and if the practitioner or pharmacist agrees with altering a medication, record

the:

(c) Name of the person who provided the consultation.

This requirement was not met as evidenced by:

Based on observation, interviews, and record review the Adult Family Home (AFH) failed to consult medical professionals before altering Resident medication with food. This failure placed 1 of 5 Residents (Resident 2) at risk of altered medication dose and effectiveness of the prescribed medications.

Findings included...

Record review showed the AFH admitted Resident 2 on [redacted]/2020 with multiple medical diagnoses including [redacted] and [redacted].

Record review of Resident 2's Negotiated Care Plan (NCP), dated on 05/31/2023, showed that Resident 2 was taking medications with apple sauce.

Observation, on 08/22/2023 at 8:03 AM, showed Resident 2 in the bed in their room. On the bedside table next to the Resident 2 was small plastic cup with apple sauce and multiple medications on the top.

In an interview, on 08/28/2023 at 6:18 PM Staff D, Provider, reported that they were not sure if they had orders from the medical professional for Resident 2 to take their medications with apple sauce. Staff D stated that Resident 2 was admitted a long time ago, and someone told them that Resident 2 prefers to take medications with apple sauce. Staff D reported that they will get back to the Department regarding the orders once they review their records. As of 09/01/2023, records were not received by the Department.

In an interview, on 08/29/2023 at 10:14 AM, Collateral Contact 1 (CC1), the pharmacist, reported that they did not have orders for medication to be placed in the food, such as apple sauce, for Resident 2. CC1 stated that all the medications would have to be reviewed by them to determine if the medication could be placed in food or altered.

In an interview, on 08/29/2023 at 4:52 PM Collateral Contact 2 (CC2), nurse delegator, reported that they did not have orders for Resident 2s' medication to be altered or placed in, or taken with, apple sauce.

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, Abiezer Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 09/20/2023 .

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

Daniel Bockretsion
Provider (or Representative)

09/16/2023
Date