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

Vashon Island Elder Care Inc
Island Elder Care
PO Box 13217
Burton, WA 98013

RE: Island Elder Care License # 754706

Dear Provider:

This letter addresses Compliance Determination(s) 55865 (Completion Date 03/05/2025) and 52722 (Completion Date 01/14/2025).

The Department completed a follow-up inspection of your Adult Family Home on 03/05/2025 and found that you have corrected the violations listed in the Full report dated 01/14/2025. Your home is back in compliance as of 03/01/2025 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 388-76-10430-2-c, WAC 388-76-10430-2-d, WAC 388-76-10430-1, WAC 388-76-10310-1, WAC 388-76-10310-2, WAC 388-76-10315-2, WAC 388-76-10315-1-g, WAC 388-76-10480-4-b, WAC 388-76-10480-4-c, WAC 388-76-10480-4-d

The Department staff who did the on-site verification:
Kirsten Biddle, AFH Licensor

If you have any questions, please contact me at (253)234-6033.

Sincerely,

Cecile Leano, Field Manager
Region 2, Unit E
Residential Care Services

STATE OF WASHINGTON
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20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 754706	Compliance Determination # 52722
Plan of Correction	Island Elder Care	Completion Date
Page 1 of 9	Licensee: Vashon Island Elder Care Inc	01/14/2025

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 01/07/2025, 01/07/2025 and 01/07/2025 of:
Island Elder Care
7319 SW 258TH PL
VASHON, WA 98070

The following sample was selected for review during the unannounced on-site visit: 4 of 5 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Kirsten Biddle, AFH Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit E
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 — 01/15/2025 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.

Theresa Shipley
Provider (or Representative)

1-24-25
Date

WAC 388-76-10430 Medication system.

(1) If the adult family home admits residents who need medication assistance or medication administration services by a legally authorized person, the home must have systems in place to ensure the services provided meet the medication needs of each resident and meet all laws and rules relating to medications.

(2) When providing medication assistance or medication administration for any resident, the home must ensure each resident:

(c) Medication log is kept current as required in WAC 388-76-10475 ;

(d) Receives medications as required.

This requirement was not met as evidenced by:

Based on observations, interviews, and record review, the Adult Family Home (AFH) failed to ensure 4 of 5 residents (Resident 1, 3, 4, and 5) received their medications as ordered and accurately documented the timing of medication provided on the medication administration record (MAR). This failure placed these residents at risk of complications from not receiving medications as ordered.

Findings included...

WAC 388-76-10475 Medication—Log.
The adult family home must:
(3) Ensure the medication log includes:
(a) Initials of the staff who assisted or gave each resident medication(s)

In an interview on 01/07/2025 at 11:50 AM, Staff C, Caregiver, reported that they usually work the evening shift, however, Staff B, Caregiver, has been finishing their online training for the last two days during the day. Both Staff B and Staff C were asked if there were residents who received medications around 12 PM or 2 PM, whereby Staff C stated only Resident 1 did with their lunch.

RESIDENT 1

Observation on 01/07/2025 at 12:23 PM showed Staff C, providing medication assistance by placing a cup with two pills, a small white round pill and the other pill an oval white shape, into Resident 1's hand, who took them each and swallowed with water.

In an interview with Staff C at 12:24 PM on 01/07/2025, they stated that the medication provided was Oxycontin (medication used for pain) and that the other pill was Tizanidine (medication for muscle spasms).

On 01/07/2025 at 12:25 PM, record reviews of Resident 1's dated, "01/2025" MAR showed "Oxycontin 15 (milligram) mg orally Q [every] 8 (hour) H for pain" as the second medication listed. The next column showed "Time" as "7am, 3pm, 11pm". Listed under the column of date boxes on the MAR, the numerical date of "5" showed the last documented dose of "7am" by Staff B. Further review of the dated, "01/2025" MAR, on page 1 showed eight medications not documented as given on 01/05/2025 at 7 PM. The medications not signed as provided at 7 PM were: Pradaxa (blood thinner medication to prevent blood clots), Oxycontin at 3 PM and 7 PM, Carvedilol (medication used to treat heart failure and high blood pressure), Preservision (vitamin and mineral supplement for eye health), Acetaminophen (pain relieving medication), Atorvastatin (medication reducing cholesterol in the blood), and Quetiapine (medication to treat mood disorder).
No medications were shown as given at any time of day for 01/06/2025 and 01/07/2025.

Record review of page 2 of the dated, "01/2025" MAR for Resident 1 showed no medications as given for 01/01/2025-01/07/2025 at 7 AM. The medications not documented as given on 01/06/2025, 7 AM and 7 PM; and 01/07/2025 at 7 AM were: Pradaxa, Vitamin D3 (medication used to treat and prevent bone disorders), Carvedilol Amlodipine, Losartan (lower high blood pressure), Preservision Acetaminophen, Atorvastatin, Spironolactone (medication used to treat high blood pressure), and Quetiapine.

In an interview with Staff C on 01/07/2025 at 12:35 PM, the Department Staff asked what time the Oxycontin and Tizanidine medications that were given to Resident 1, were supposed to be for; as the MAR showed nothing had been documented as given the last couple days for Oxycontin and not given at all in the month of January for the Tizanidine. Staff C then looked at Staff A, Provider, asking if the MAR had been changed. Staff A did not reply.

Additional record review of Resident 1's dated, "12/2024" MAR showed no medications that were documented as given on page 1 from 12/01-12/04/2024. This totaled to 68 doses of scheduled medications that were not documented as given. On page 2, the "12/2024" dated MAR showed no medications as given from 12/01-12/19/2024. On 12/24/2024 and 12/31/2024, the MAR on page 1 and 2 showed blank columns, or 15 medications not given that Resident 1 was prescribed. There was no MAR found for the month of November 2024.

In an interview with Staff C at 12:41 PM on 01/07/2025, they reported to give the medications as prescribed to Resident 1. Staff C stated that Staff A took the November MAR home at the end of the month to make updates for the December MAR.

RESIDENT 3

Record review on 01/07/2025 at 12:35 PM, showed Resident 3's MAR dated, "12/2024" as blank, or no initials under the dated columns. There were eight medications that were prescribed and not documented as given from 12/01/-12/31/2024.
The eight medications listed on the MAR were: Sertraline (medication for mood disorder), Terazosin (medication for treatment of high blood pressure and enlarged prostate), Vitamin D3, Ferrous Sulfate (medication for iron deficiency), Vitamin C (nutrient to form blood vessels, cartilage, muscles, and collagen in bones), Olanzapine (medication to manage symptoms of mood disorder), Mirtazapine (medication for mood disorder), B12 vitamin (nutrient to maintain healthy nerve and blood cells), Senna (medication to treat constipation), Zinc (nutrient that aids in metabolic function), and Fluticasone (medication to treat nasal congestion, asthma).

Additional review on 01/07/2025, for Resident 3's dated, "01/2025" MAR showed the dated columns initialed from 01/01-01/08/2025. The MAR was initialed up to 01/08/2025, one day ahead of the actual date.

In an interview with Staff C at 1:35 PM on 01/07/2025, they could not answer as to why there was a blank "12/2024" MAR for Resident 2, stating they gave the medications as prescribed and documented such. Staff C was asked why the dated column for 01/08/2025, was filled out in the "01/2025" MAR, in which they reported to have been mixed up from working a different time of day.

RESIDENT 4

Record review of the MARs for Resident 4 on 01/07/2025, did not show a November 2024 MAR. The review of the dated, "12/24" MAR for Resident 4 showed blank for 12/23/2024, for four of the eight prescribed medication times. The MAR showed blank boxes for the prescribed Quetiapine at noon and 8PM, Trazadone (medication for mood disorder) 8 PM, and Acetaminophen at 8 PM. On 12/24/2024, no initials were shown documenting the medications as given for any of Resident 4's prescribed medications. On 12/25/2024, the 8 AM dose of Quetiapine was shown to be blank along with the 8 AM Sertraline and Acetaminophen medications.
Further review of the dated, "12/24" MAR showed that 12/30/2024 and 12/31/2024 were blank, or no initials next to the prescribed medications as given for Resident 4, except for the Quetiapine at 8 AM on 12/30/2024.

In an interview with Staff C at 4:10 PM, the Department Staff asked why there was only one dosage of medication (Quetiapine) given to Resident 3 on the 30th of December, and nothing else documented as given for that day and the 31st. Staff C stated, "Oh was there 31 days in December?".

Additional review on 01/07/2025, for Resident 4's dated, "01/2025" MAR showed the dated columns initialed from 01/01-01/08/2025. The MAR was initialed up to 01/08/2025, one day ahead of the actual date.

RESIDENT 5

Record review of the MARs for Resident 5 on 01/07/2025 did not show a November 2024 MAR.

Review of the dated, "12/2024" MAR for Resident 5 showed a blank box for 12/06/2024, for Memantine (medication for memory loss) at 8 PM, Vitamin B12 at 8 PM, and Vitamin C at 8 PM. For 12/07, 12/24/2024 and 12/31/2024 – the boxes were shown as blank, or that eight medications as prescribed were not given to Resident 5. The eight medications not initialed as given are: Sertraline, Memantine, Multivitamin, Vitamin B12, Vitamin C, Oxybutynin (medication used to treat an overactive bladder), Magnesium (nutrient for regulating muscle and nerve function, blood sugar levels, and blood pressure and making protein, bone, and deoxyribonucleic acid [the molecule that carries genetic information for the development and functioning of an organism], and Cranberry (supplement that may reduce frequency of urinary tract infections).
Additional review on 01/07/2025, for Resident 5's dated, "01/2025" MAR showed the dated columns initialed from 01/01-01/08/2025. The MAR was initialed up to 01/08/2025, one day ahead of the actual date.

In an interview with Staff A on 01/07/2025 at 1:40 PM, the missing MARs for Residents 1, 3, 4 and 5 were discussed. Staff A reported that the missing MARs was "clearly an oversight".

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, Island Elder Care is or will be in compliance with this law and / or regulation on (Date) 3-1-25 .

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

Theresa Shipley — Provider (or Representative)

1-24-25 — Date

WAC 388-76-10310 Tuberculosis Test records. The adult family home must:

(1) Keep the records of tuberculin test results, reports of X-ray findings, and any physician or public health provider orders in the adult family home;

(2) Make the records readily available to the appropriate health authority and licensing agency;

This requirement was not met as evidenced by:

Based on observation, interviews and record reviews, the Adult Family Home (AFH) failed to maintain tuberculosis records for 2 of 4 staff (Staff B and C, Caregivers). This failure placed residents at a potential risk of exposure to a communicable disease as there was no verification made of the tests had been performed.

Findings included...

Review of the Centers for Disease Control and Prevention website on 01/14/2025 - About Tuberculosis | Tuberculosis (TB) | CDC under "Overview", the website shows the definition of tuberculosis (TB) "is caused by a bacterium called Mycobacterium tuberculosis... TB usually affects the lungs. TB can also affect other parts of the body, such as the brain, the kidneys, or the spine... Not everyone infected with TB bacteria becomes sick." Further review of the webpage - Clinical Testing Guidance for Tuberculosis: Health Care Personnel | TB Prevention in Health Care Settings | CDC; under "Screening guidelines" the webpage showed, "All U.S. health care personnel should be screened for TB upon hire (i.e. preplacement). TB screening is a process that includes: ...

- A TB test (e.g., TB blood test or a TB skin test), and
- Additional evaluation for TB disease as needed."

Observation made on 01/07/2025 at 11:42 AM, showed Staff B, opening the door to the AFH. In an interview with Staff B, they reported that they have been working at the AFH for about three months. Staff C came out from the hallway and introduced themselves, stated to have worked at the AFH for about "seven years".

Record review on 01/07/2025 at 3:35 PM, showed personnel records for staff currently working at the AFH. Staff B's personnel records showed a letter from another state's health department dated "01/07/2022" of a "Negative TB Test (2-step)".
In an interview with Staff A, Provider, and Staff B at 3:41 PM on 01/07/2025, Department Staff requested any additional TB records where Staff B responded that were previously employed at this AFH and were re-hired about three months prior. No additional TB records following the recent re-employment in 2024 were found.

Further review of personnel records for Staff C showed a hire date of 08/17/2020. A document with Staff C's name on it showed a negative TB test from 04/2024. No other TB test information was found in the personnel records.

In an interview with Staff C on 01/07/205 at 3:53 PM, the Department Staff asked if they had any TB records from when they first were hired in 2020. Staff C stated they were "re-hired" in 2024 and referred to the time frame of the TB test found in the personnel records, unable to report a date of "re-hire".

On 01/08/2025 at 8:04 AM, a request in email was sent to Staff A requesting documentation including any TB personnel records for Staff B and C, along with their "re-hire" dates. On 01/09/2025 at 1:30 PM, requested documentation was received except for the TB records. Another request for TB personnel records was made on 01/10/2025 at 4:10 PM.

In an interview with Staff A on 01/13/2025 at 4:40 PM, they reported that no other TB records were found for Staff B and C.

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, Island Elder Care is or will be in compliance with this law and / or regulation on (Date) 3-1-25 .

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

Theresa Shipley — Provider (or Representative)

3-1-25 — Date

WAC 388-76-10315 Resident record Required. The adult family home must:

(1) Create, maintain, and keep records for residents in the home where the resident lives and ensure that the records:

(g) Be available so that department staff may review them when requested; and

(2) Ensure staff has access to the parts of residents' records needed by staff to provide care and services; and

This requirement was not met as evidenced by:

Based on observation and interviews, the Adult Family Home (AFH) did not have 4 of 5 resident records located on site. This failure placed a delay in receiving the resident information when requested by Department Staff (DS) at the inspection of the AFH to determine compliance with the regulations.

Findings included...

In an interview with Staff A, Provider, at 1:02 PM on 01/07/2025, they stated that there were five residents lived in the home.

In an interview with Staff C, Caregiver, on 01/07/2025 at 2:03 PM, resident records were requested to review by DS. Staff C stated that Staff A, had them in their possession.

In an interview with Staff A at 2:06 PM on 01/07/2025, they reported to have the resident records in their possession, at their home.

On 01/08/2024 at 8:04 AM, a request for resident records via email was made to be faxed to the Department. The request was received on 01/09/2025.

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, Island Elder Care is or will be in compliance with this law and / or regulation on (Date) 1-20-25 .

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

Theresa Shipley — Provider (or Representative)

1-24-25 — Date

WAC 388-76-10480 Medication organizers. The adult family home must ensure:

(4) Medication organizer labels clearly show the following:

(b) A list of all prescribed and over-the-counter medications;

(c) The dosage of each medication;

(d) The frequency which the medications are given.

This requirement was not met as evidenced by:

Based on observations and interviews, the Adult Family Home (AFH) failed to ensure the medication organizer for 1 of 5 residents (Resident 1) was labeled as required. This failure placed the resident at risk of a medication misuse or potential for medication error.

Findings included...

Observation on 01/07/2025 at 2:20 PM, showed a medication organizer that contained medications for Resident 1 brought out from the locked medication storage cabinet located in the kitchen, left of the refrigerator. The plastic pill box organizer showed Resident 1's name and the days of the week with an "am" for morning, and "pm" for evening, with a total of 14 compartments. There was no information shown as to the name of medications or timing/frequency of doses.

In an interview with Staff A, Provider, on 01/07/2025 at 2:25 PM, discussion included the observed medication organizer for Resident 1. Staff A reported that they refill medications regularly which are either mailed or picked up directly from the pharmacy by them. Staff A stated that they were unaware that the medication names and frequency were needed to be labeled on the organizer.

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, Island Elder Care is or will be in compliance with this law and / or regulation on (Date) 1-20-25 .

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

Theresa Shipley
Provider (or Representative)

1-24-25
Date

TO: Cecile Leano, Field Manager

FAX: 253-234-6004 1-253-395-5071

FROM: Theresa Shipley

DATE: 1/24/25

Attached is the PLAN OF CORRECTIONS.

Regarding the Medication System I am coordinating with the local pharmacy to provide bubble packs of medications and monthly MARS. This is a new service for them so we plan to implement by March 1, 2025 if not sooner. In the interim I am following the Medication Safety Plan and am reviewing daily the medications for documentation and reconciliation.