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

5MCANDA LLC
A Sand Point Senior Care
11314 SAND POINT WAY NE
SEATTLE, WA 98125

RE: A Sand Point Senior Care License # 755005

Dear Provider:

This letter addresses Compliance Determination(s) 47431 (Completion Date 09/18/2024) and 44506 (Completion Date 08/23/2024).

The Department completed a follow-up inspection of your Adult Family Home on 09/18/2024 and found that you have corrected the violations listed in the Full report dated 08/23/2024. Your home is back in compliance as of 09/06/2024 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 388-76-10380-2, WAC 388-76-10430-1, WAC 388-76-10430-2-c, WAC 388-76-10430-2-d

The Department staff who did the on-site verification:
Rivi Stella Perez

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

Sincerely,

Alfredo Brown

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

Statement of Deficiencies	License #: 755005	Compliance Determination # 44506
Plan of Correction	A Sand Point Senior Care	Completion Date
Page 1 of 9	Licensee: 5MCANDA LLC	08/23/2024

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 07/23/2024 and 07/23/2024 of:

A Sand Point Senior Care
11314 SAND POINT WAY NE
SEATTLE, WA 98125

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

The department staff that inspected the Adult Family Home:

Rivi Stella Perez

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

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Alfredo Brown
Residential Care Services

09/06/2024
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.

Statement of Deficiencies	License #: 755005	Compliance Determination # 44506
Plan of Correction	A Sand Point Senior Care	Completion Date
Page 2 of 9	Licensee: 5MCANDA LLC	08/23/2024

Provider (or Representative) 9/6/2024 Date

WAC 388-76-10380 Negotiated care plan Timing of reviews and revisions. The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:

(2) When the plan, or parts of the plan, no longer address the resident's needs and preferences;

This requirement was not met as evidenced by:

Based on observation, record review and interview, the Adult Family Home (AFH) failed to ensure 5 of 6 residents (Residents 1, 2, 3, 4 and 6) Negotiated Care Plans (NCP) were reviewed and updated to reflect the status and care needs of Resident 1, Resident 2, Resident 3, Resident 4 and Resident 6. These failures placed Residents 1, 2, 3, 4 and 6 at risk for unrecognized care needs and decreased quality of life.

Findings included...

RESIDENT 1
Review of the AFH records showed Resident 1 admitted to the AFH on [redacted]2023 with multiple diagnoses.

Review of Resident 1's NCP, dated 06/19/2024, showed "bathing" and "dressing" sections were marked as "total assistance" (resident is totally dependent on caregiver to do the task).

During an interview on 07/29/2024 at 2:26 PM, Staff A, Entity Representative, stated that Resident 1 was able to carry out some their own bathing related tasks. Staff A stated that caregivers would assist Resident 1 with completing the bathing tasks that Resident 1 was unable to complete on their own. Staff A stated that they would change the NCP for "bathing" to extensive assist (resident is able to participate and do the task with help or assistance from caregiver).

During an interview on 07/29/2024 at 2:30 PM, Staff A stated that Resident 1 was able to put their hands inside the shirt after the caregiver had assisted them with placing the shirt over their head. Staff A stated Resident 1 was an extensive assist for the upper body dressing and a total assist for putting on pants.

Review of Resident 1's NCP, dated 06/19/2024, showed under "personal hygiene" that

Provider (or Representative) Date

WAC 388-76-10380 Negotiated care plan Timing of reviews and revisions. The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:

(2) When the plan, or parts of the plan, no longer address the resident's needs and preferences;

This requirement was not met as evidenced by:

Based on observation, record review and interview, the Adult Family Home (AFH) failed to ensure 5 of 6 residents (Residents 1, 2, 3, 4 and 6) Negotiated Care Plans (NCP) were reviewed and updated to reflect the status and care needs of Resident 1, Resident 2, Resident 3, Resident 4 and Resident 6. These failures placed Residents 1, 2, 3, 4 and 6 at risk for unrecognized care needs and decreased quality of life.

Findings included...

RESIDENT 1
Review of the AFH records showed Resident 1 admitted to the AFH on [redacted]/2023 with multiple diagnoses.

Review of Resident 1's NCP, dated 06/19/2024, showed "bathing" and "dressing" sections were marked as "total assistance" (resident is totally dependent on caregiver to do the task).

During an interview on 07/29/2024 at 2:26 PM, Staff A, Entity Representative, stated that Resident 1 was able to carry out some their own bathing related tasks. Staff A stated that caregivers would assist Resident 1 with completing the bathing tasks that Resident 1 was unable to complete on their own. Staff A stated that they would change the NCP for "bathing" to extensive assist (resident is able to participate and do the task with help or assistance from caregiver).

During an interview on 07/29/2024 at 2:30 PM, Staff A stated that Resident 1 was able to put their hands inside the shirt after the caregiver had assisted them with placing the shirt over their head. Staff A stated Resident 1 was an extensive assist for the upper body dressing and a total assist for putting on pants.

Review of Resident 1's NCP, dated 06/19/2024, showed under "personal hygiene" that

Resident 1 was, "able to brush teeth/dentures partially, able to take dentures in/out".

During an interview on 07/29/2024 at 2:32 PM, Staff A stated that Resident 1 liked to shave with an electric razor. Staff A stated that Resident 1 shaved with staff supervision. Staff A stated that they would change Resident 1's NCP for "personal hygiene" from total assist to extensive assist.

Review of Resident 1's NCP, dated 06/19/2024, showed Resident 1 used Miconazole (medication to treat skin issues caused by fungus) skin cream.

During an interview on 07/29/2024 at 2:28 PM, Staff A stated that Resident 1 was using the Miconazole medication to treat their facial skin condition. Staff A stated they would check to see Resident 1's Miconazole medication order was discontinued.

Review of Resident 1's July 2024 Medication Log showed no order for Miconazole.

RESIDENT 2
Review of the AFH records showed Resident 2 admitted to the AFH on [redacted]/2023 with multiple diagnoses including [redacted].

Observation on 07/23/2024 at 2:00 PM, showed a sound could be heard in the living room area.

During an interview on 07/23/2024 at 2:00 PM, Staff A stated that sound was coming from the "baby monitor" inside Resident 2's bedroom.

Observation on 7/23/2024 at 2:45 PM, showed a baby monitor was observed on Resident 2's nightstand. The baby monitor had an audio only feed and was turned on.

During an interview on 07/23/2024 at 2:45 PM, Resident 2 stated that they were aware of the use of the baby monitor. Resident 2 stated that they were unable to use their arms to call for help. Resident 2 stated that they would ask the caregivers to turn off the monitor when they had visitors or when they wanted to protect their privacy.

Review of Resident 2's NCP, with a review date of 12/06/2023, did not show any information regarding use of a baby monitor. There was no information on how Resident 2 would use the baby monitor and the caregiver's action related to use of the baby monitor.

Review of Resident 2's NCP, with a review date of 12/06/2023, showed it was not

marked for hospice and the use of hospice comfort kit medication.

During an interview on 07/29/2024 at 2:37 PM, Staff A stated that Resident 2 had transitioned to hospice care in February or March 2024. Staff A stated Resident 2's hospice care plan was available. Staff A stated Resident 2's NCP did not show hospice care plan.

Record review of Resident 2's July 2024 Medication Log showed an order for Lorazepam (anti-anxiety medication).

During an interview on 07/09/2024 at 2:40 PM, Staff A stated that Resident 2's Lorazepam for shortness of breath was part of the hospice comfort kit. Staff A stated they would look at the NCP if there was Lorazepam listed for shortness of breath.

Record review of Resident 2's NCP, with a review date of 12/06/2023, showed no information regarding use of Lorazepam for shortness of breath as part of the hospice comfort kit.

During an interview on 07/29/2024 at 2:41 PM, Staff A stated that Resident 2 was using continuous positive airway pressure machine (CPAP) (a machine that delivers pressurized air through a mask to keep a person's airways open while they sleep and improve their health). Staff A stated that Resident 2 used the CPAP machine during the day and at night to get rid of the carbon dioxide (a colorless, odorless gas that is naturally present in the air, which people breathe out when people exhale) in their system.

Review of Resident 2's NCP, with a review date of 12/06/2023, showed no information regarding use of CPAP machine, when Resident 2 will use their CPAP machine, and no instructions on the caregiver's role related to the use and care of Resident 2's CPAP machine.

RESIDENT 3
Review of the AFH records showed Resident 3 admitted to the AFH on [redacted]/2022 with multiple diagnoses.

Observation on 07/23/2024 at 8:51 AM, showed Resident 3 was in bed with a [redacted] hanging over the bed and a [redacted] on the upper side of the bed.

Review of Resident 3's NCP, dated 08/22/2023, under "ambulation/transfers", showed Resident 3 needed "total assist". Under "client abilities and preferences", it showed that Resident 3 was "able to pull himself up with the use of [redacted]" and "able to use upper extremities to hold on to the [redacted] for turning…"

During an interview on 07/29/2024 at 2:42 PM, Staff A stated that Resident 3 was able to use the overhead [redacted]. Staff A stated Resident 3 would hold onto the [redacted] when caregivers assisted Resident 3 with putting on their shirt. Staff A stated that Resident 3 was able to hold onto the [redacted] for turning and repositioning self in bed. Staff A stated that Resident 3 was an extensive assist and should not have been marked as a "total assist" on the NCP.

RESIDENT 4
Review of the AFH records showed Resident 4 admitted to the AFH on [redacted]/2022 with multiple diagnoses.

Observation on 07/23/2024 at 11:31 AM, showed Resident 4 was in bed with [redacted] and a [redacted].

Review of Resident 4's NCP, dated 10/06/2023, stated under "ambulation/transfers" that Resident 4 was utilizing "[redacted]." Resident 4's NCP had no additional information on the type and number of [redacted] to use. Resident 4's NCP had no information regarding Resident 3's utilization of a [redacted]

During an interview on 07/29/2024 at 2:52 PM, Staff A stated that Resident 4 was able to use the [redacted] on and off. Staff A stated Resident 4 would use the [redacted] for standing up and getting out of bed. Staff A stated Resident 4 would grab the [redacted], stand up, and then sit on their wheelchair.

During an interview on 07/29/2024 at 2: 54 PM, Staff A stated that Resident 4 was using [redacted] in bed for turning and during hygienic care. Staff A stated the NCP did not have information regarding use of [redacted] and information on the type and number of [redacted] used.

RESIDENT 6
Review of the AFH records showed Resident 6 admitted to the AFH on [redacted]/2022 with multiple diagnoses.

Observations on 07/23/2024 at 8:53 AM and 11:03 AM, showed Resident 6 was in bed with [redacted] in the raised position.

During an interview on 07/23/2024 at 11:03 AM, Resident 6 stated that they would use the [redacted] to turn in bed.

Record review of Resident 4's NCP, dated 08/06/2023, stated under "ambulation/transfers" that Resident 6 needed "total assist". The NCP was marked for

Statement of Deficiencies	License #: 755005	Compliance Determination # 44506
Plan of Correction	A Sand Point Senior Care	Completion Date
Page 6 of 9	Licensee: 5MCANDA LLC	08/23/2024

use of [redacted] but contained no information on the type and number of [redacted] Resident 6 used.

During an interview on 07/29/2024 at 2:45 PM, Staff A stated that Resident 6 would use the [redacted] by holding onto the [redacted] for help with turning and hygienic care. Staff A stated that Resident 6 used [redacted]. Staff A stated that the [redacted] should be in the raised position when Resident 6 was in bed. Staff A stated that they did not know the difference between total assist and extensive assist. Staff A stated that they would update Resident 6's NCP for "ambulation/transfers" to extensive assist.

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, A Sand Point Senior Care is or will be in compliance with this law and / or regulation on (Date) 9/6/2024

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

Provider (or Representative) — Date: 9/6/2024

WAC 388-76-10430 Medication system.

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

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

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

(d) Receives medications as required.

This requirement was not met as evidenced by:

Based on observation, record review and interview, the AFH failed to ensure 2 of 2 sampled (Resident 1 and Resident 2) received all medications as prescribed, had an up-to-date Medication Log (ML) and had all prescribed medications available on site. These failures placed Resident 1 and 2 at risk for not getting all the medications prescribed for them and for medication errors.

Finding included...

RESIDENT 1

use of [redacted] but contained no information on the type and number of [redacted] Resident 6 used.

During an interview on 07/29/2024 at 2:45 PM, Staff A stated that Resident 6 would use the [redacted] by holding onto the [redacted] for help with turning and hygienic care. Staff A stated that Resident 6 used [redacted]. Staff A stated that the [redacted] should be in the raised position when Resident 6 was in bed. Staff A stated that they did not know the difference between total assist and extensive assist. Staff A stated that they would update Resident 6's NCP for "ambulation/transfers" to extensive assist.

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, A Sand Point Senior Care 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 388-76-10430 Medication system.

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

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

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

(d) Receives medications as required.

This requirement was not met as evidenced by:

Based on observation, record review and interview, the AFH failed to ensure 2 of 2 sampled (Resident 1 and Resident 2) received all medications as prescribed, had an up-to-date Medication Log (ML) and had all prescribed medications available on site. These failures placed Resident 1 and 2 at risk for not getting all the medications prescribed for them and for medication errors.

Finding included...

RESIDENT 1

Review of the AFH records showed Resident 1 admitted to the AFH on [redacted]/2023 with multiple diagnoses.

Review of Resident 1's July 2024 ML showed a written order on 04/20/2024 for Vitamin C (supplement) 1000 mg (milligram), take 2 tablets (2000mg) by mouth daily at noon. There was no initial indicating that the Vitamin C had been administered for the 12:00 PM dose for 7/23/2024.

Observation on 07/23/2024 at 1:59 PM, showed there was no supply of Vitamin C available on site.

During an interview on 07/23/2024 at 1:59 PM, Staff A, Entity Representative, stated they ran out of Vitamin C a few days ago and the guardian was out of the country to bring it. At 2:04 PM, Staff A stated the caregivers should have put "N/A" (not available) on the ML on the day the medication was not available.

During a follow-up interview on 07/29/2024 at 3:22 PM, Staff A stated if the medication was not available, the caregiver should initial the medication, put a circle around their initial and write a note in the back of the ML that the medication was not available or was missing.

Review of Resident 1's July 2024 ML showed it had been pre-signed by Staff A for "8 PM" of 07/23/2024. The initialed medications were for: Atorvastatin (lowers cholesterol), Docusate Sodium (stool softener), Escitalopram (antidepressant) and Melatonin (sleep aide).

Review of Resident 1's July 2024 ML had been pre-signed by Staff A for "7:30 AM" of 07/24/2024 for the Levothyroxine (thyroid medication).

Review of Resident 1's July 2024 ML had been pre-signed by Staff A for "8 AM" of 07/24/2024. The initialed medications were for: Amlodipine (controls blood pressure), Certavite (supplement), Docusate Sodium, Finasteride (help improve urinary symptoms for people with enlarged prostate), Flonase nasal spray (allergy medication), Loratadine (allergy medicine), and Metronidazole cream (antifungal cream).

During an interview on 07/23/2024 at 2:08 PM, Staff A stated they thought the date of 07/23/2024 was 7/24/2024. Staff A stated that they had signed the ML for the evening doses of 07/23/2024 and morning doses for 07/24/2024. Staff A stated that they thought the ML was not signed during the date of the inspection. Staff A stated that they should not have signed the ML if they did not give the medication themselves.

RESIDENT 2
Review of the AFH records showed Resident 2 admitted to the AFH on [redacted]/2023 with

multiple diagnoses.

Observation and record review on 07/23/2024 at 1:34 PM, showed a supply of Lorazepam (anti-anxiety medication) 2mg/ml (milligram/milliliter) oral concentrate bottle and placed in a box with a prescription label. The prescription label, dated 07/18/2024, read: "Take 0.25 ml (0.5 mg) by mouth every 1 hour as needed for shortness of breath or anxiety between 6am-9pm and may take 0.5 milliliter (ml) (1 mg) every 1 hour as needed for shortness of breath/anxiety/insomnia [a sleep disorder that makes it hard for people to fall asleep or stay asleep] between 9 pm-6am."

Record review of the "0401124-043024" ML provided showed 2 orders for Lorazepam:

1) A typewritten order for Lorazepam, dated 03/08/2024, stating "Take 0.25 ml (0.5 mg) by mouth every hour as needed for shortness of breath, anxiety, or agitation. *Refrigerate and discard opened bottle after 90days. (CMFT KIT) [comfort kit]". The scheduled times were: "CMFT PRN [comfort – as needed]", 5 AM, 9 AM, 1 noon, 3 PM, 5PM, 7 PM" and were initialed by caregivers daily from July 1 to July 24, 2024.

2) An undated handwritten order for Lorazepam stating, "Take 0.5 ml (1mg) by mouth before bedtime". The scheduled time was "10 PM" and initialed by caregiver daily from July 1 to July 24, 2024.

During an interview on 07/23/2024 at 1:34 PM, Staff A stated that Resident 2 was very regimented. Staff A stated the Lorazepam medication was given at 10:00 PM, which was within the order timeframe of 9:00 PM to 6:00 AM. Staff A stated the medication was being given as needed and can be administered at another time if needed. Staff A stated they would just indicate the time when Resident 2 would take it.

During an interview, on 07/23/2024 at 1:39 PM, Staff A stated the order on the ML did not match the order on the prescription label. Staff A stated that the Lorazepam order had a scheduled time on ML. Staff A stated the Lorazepam was written as a scheduled dose instead of the "as needed" order. Staff A stated that Resident 2 did not want the medication given as a scheduled dose.

Review of Resident 2's ML showed it was not dated or labeled for July 2024. The ML showed "Charting for/through 040124-043024" [April 1-30, 2024] on the area where the information for the month and year would be indicated.

During an interview on 07/23/2024 at 1:41 PM, Staff A stated the hospice provided Resident 2's medications for July 2024. Following review of the date on what was supposed to be the July 2024 ML, Staff A stated they had photocopied the ML for April 2024. Staff A stated that Staff C, Caregiver, did not realize the date was incorrect when they photocopied the ML. Staff A stated the hospice would need to create an ML for July 2024.

Statement of Deficiencies	License #: 755005	Compliance Determination # 44506
Plan of Correction	A Sand Point Senior Care	Completion Date
Page 9 of 9	Licensee: 5MCANDA LLC	08/23/2024

Review of Resident 2's ML labeled "0401124-043024" showed it had been pre-signed by Staff A for "8 PM" of 07/23/2024. The initialed medications were for: Acetaminophen (pain medication) and Gabapentin (medication to manage nerve pain).

Review of Resident 2's ML labeled "0401124-043024" showed it had been pre-signed by Staff A for "10 PM". The initialed medications were for: Aspercreme (pain patch) and gas relief medication.

Review of Resident 2's ML labeled "0401124-043024" showed Staff A had pre-signed the Lorazepam medication for the following scheduled times: 3:00 PM, 5:00 PM, 9:00 PM and 10:00 PM of 07/23/2024 and 5:00 AM and 9:00 AM for 7/24/2024.

During an interview on 07/23/2024 at 2:09 PM, Staff A stated they thought the date of 07/23/2024 was 7/24/2024. Staff A stated that they had signed the ML for the evening doses of 07/23/2024 and morning doses for 07/24/2024. Staff A stated that they thought the ML was not signed during the date of the inspection. Staff A stated that they should not have signed the ML if they did not give the medication themselves.

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, A Sand Point Senior Care is or will be in compliance with this law and / or regulation on (Date) 9/6/2024.

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

Provider (or Representative) 9/6/2024 Date

Review of Resident 2's ML labeled "0401124-043024" showed it had been pre-signed by Staff A for "8 PM" of 07/23/2024. The initialed medications were for: Acetaminophen (pain medication) and Gabapentin (medication to manage nerve pain).

Review of Resident 2's ML labeled "0401124-043024" showed it had been pre-signed by Staff A for "10 PM". The initialed medications were for: Aspercreme (pain patch) and gas relief medication.

Review of Resident 2's ML labeled "0401124-043024" showed Staff A had pre-signed the Lorazepam medication for the following scheduled times: 3:00 PM, 5:00 PM, 9:00 PM and 10:00 PM of 07/23/2024 and 5:00 AM and 9:00 AM for 7/24/2024.

During an interview on 07/23/2024 at 2:09 PM, Staff A stated they thought the date of 07/23/2024 was 7/24/2024. Staff A stated that they had signed the ML for the evening doses of 07/23/2024 and morning doses for 07/24/2024. Staff A stated that they thought the ML was not signed during the date of the inspection. Staff A stated that they should not have signed the ML if they did not give the medication themselves.

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, A Sand Point Senior Care 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

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

09/06/2024

5MCANDA LLC
A Sand Point Senior Care
11314 SAND POINT WAY NE
SEATTLE, WA 98125

RE: A Sand Point Senior Care # 755005

Dear Provider:

The Department completed a full inspection of your Adult Family Home on 08/23/2024 and found that your home does not meet the Adult Family Home Licensing requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect the home to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Alfredo Brown, Field Manager
Residential Care Services
Region 2, Unit K
20311 52nd Ave W, Suite 100

Lynnwood, WA 98036

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-76-10015 License Adult family home Compliance required.

(1) The licensed adult family home must comply with all the requirements established in chapters 70.128 , 70.129, 74.34 RCW, this chapter and other applicable laws and regulations including chapter 74.39A RCW; and

(2) The provider is ultimately responsible for the day-to-day operation of each licensed home.

(3) The provider must promote the health, safety, and well-being of each resident residing in each licensed adult family home.

The Adult Family Home (AFH) failed to meet applicable laws and regulations related to respiratory protection and obtain a Medical Test Site Waiver (MTSW) license. These failures placed the employees and the residents at risk of contracting COVID-19 (an infectious disease caused by the SARS-CoV-2 virus) and the AFH operating without a MTSW license when they collected specimens and interpreted result from a conducted COVID-19 antigen home test (type of COVID-19 test that determines the level of the virus in the body). The AFH had completed medical evaluation, fit testing and training for use of respirators (device designed to protect the wearer from inhaling hazardous airborne virus) and had records on file for all current employees on 07/25/2024 and had applied for and was waiting for the MTSW license to arrive.

WAC 388-76-10320 Resident record Content. The adult family home must ensure that each resident record contains, at a minimum, the following information:

(10) A current inventory of the resident's personal belongings dated and signed by:

(a) The resident; and

(b) The adult family home.

The Adult Family Home (AFH) failed to ensure 1 of 2 sampled residents (Resident 2) inventory of personal belongings form was signed and dated by Resident 2 or Resident 2's representative. This failure placed Resident 2 at risk of lost, stolen, or misplaced personal property. The AFH had Resident 2's representative sign and date the personal

belongings inventory form on 07/25/2024.

WAC 388-76-10375 Negotiated care plan Signatures Required. The adult family home must ensure that the negotiated care plan is agreed to and signed and dated by the:

(1) Resident; and

The Adult Family Home (AFH) failed to ensure 2 of 2 sampled residents (Residents 1and Resident 2) Negotiated Care Plans (NCP) were signed and dated by the residents or their representatives. This failure placed Residents 1 and Resident 2 at risk for receiving care and services that were not agreed to by all parties. The AFH had Resident 1's Representative sign and date the NCP on 07/24/2024 and had Resident 2's representative sign and date the NCP on 07/25/2024.

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Ask for a informal dispute resolution meeting, according to the attached 'Informal Dispute Resolution' instructions; and
• Ask questions and provide written information to help clarify or dispute the deficiencies.

• Contact me for clarification of the deficiency or deficiencies found.

If You Have Any Questions:

• Please contact me at (253)341-7376.

Sincerely,

Alfredo Brown

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

Enclosure

Plan
(Plan of Correction)

You Must:

Return the plan, on the enclosed report, within 10 calendar days after you receive

this letter.

Include the following in your plan for each deficiency:

- The date you have or will correct each deficiency; and
- Provide a signature and date certifying that you have or will take corrective measures to correct each cited deficiency.

Send your plan to:
Alfredo Brown, Field Manager
Residential Care Services
Region 2, Unit K
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

INFORMAL DISPUTE RESOLUTION [RCW 70.128]

You May:
Request an Informal Dispute Resolution (IDR) meeting within 10 working days after the date you receive this letter. You **must** use an **'IDR Request Form'** for **each** citation or enforcement you plan to dispute. You can find this form and directions on the IDR Adult Family Home web page at: https://www.dshs.wa.gov/altsa/idr

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Provider Process for Choosing a Panel or Traditional IDR:

You may only choose a **Panel IDR** if you are disputing **three or fewer** citations or enforcement actions. You may choose a **Traditional IDR** regardless of the number of citations or enforcement actions you intend to dispute. If you choose a **Panel IDR**, all documents supporting your dispute must be submitted within **20 working days** after the date you receive this letter. For **Panel IDRs** the program will not consider any documents submitted after the **20 working day deadline**. For **Traditional IDRs** you should submit documents supporting your dispute at least **seven** days prior to the date of the IDR meeting.

Send your request and supporting documents to the address below or email to rcsidr@dshs.wa.gov:

Adult Family Home IDR Program
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600