STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

Mountain View AFH LLC
Maple Park Adult Family Home LLC
2545 Mountain View Rd
Ferndale, WA 98248

RE: Maple Park Adult Family Home LLC License # 755774

Dear Provider:

This letter addresses Compliance Determination(s) 47172 (Completion Date 09/13/2024) and 42766 (Completion Date 07/16/2024).

The Department completed a follow-up inspection of your Adult Family Home on 09/13/2024 and found that you have corrected the violations listed in the Follow up report dated 07/16/2024. Your home is back in compliance as of 08/15/2024 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 388-76-10430-2-d, WAC 388-76-10475-1, WAC 388-76-10475-2-b, WAC 388-76-10475-3-c-ii, WAC 388-76-10475-3-c, WAC 388-76-10475-3-c-i

The Department staff who did the on-site verification:
Jennifer Nichols, Community Complaint Investigator

If you have any questions, please contact me at (206)348-9350.

Sincerely,

Nicholette Flynn, Field Manager
Region 2, Unit B
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

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 06/14/2024 and 06/14/2024 of:

Maple Park Adult Family Home LLC
319 S PARK ST
LYNDEN, WA 98264

This document references the following SOD dated: 07/16/2024

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

The department staff that inspected the Adult Family Home:

Jennifer Nichols, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

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

(d) Receives medications 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 medications were received as required for 1 of 5 residents (Resident 4). This failure resulted in Resident 4 not receiving all prescribed medications and placed them at risk for medical complications and increased anxiety.

Findings included...

Record review showed the AFH admitted Resident 4 on [redacted]/2009 with multiple diagnoses that included [redacted]. Review of Resident 4's assessment, dated 03/04/2024, showed Resident 4 required caregivers assistance with medications.

Review of Resident 4's home visit summary from their health care provider (HCP), dated 03/14/2023, showed that Resident 4 had an order for Clonazepam (a medicine used to treat anxiety and sudden attacks of panic or fear) 0.5 milligrams to be given once daily at 6:00 PM.

Record review of Resident 4's medication log (ML), dated 05/01/2024 – 05/31/2024, showed the caregiver did not document for the administration of Clonazepam from 05/01/2024 through 05/31/2024.

Record review of Resident 4's ML, dated 06/01/2024 – 06/31/2024, showed the caregiver did not document for the administration of Clonazepam from 06/01/2024 through 06/13/2024. The Clonazepam order had a hand-written mark across the dates fields that it was discontinued, with no date it was discontinued.

In an interview, on 06/14/2024 at 12:50 PM, Staff B (Resident Manager) stated that the most recent orders they had for Resident 4 was the home visit summary from their HCP dated 03/14/2023. Staff B stated they did not have any Clonazepam to give to Resident 4, so they did not receive it 06/01/2024 through 06/13/2024. Staff B stated they could

not locate the order to discontinue Resident 4's Clonazepam and did not know when it was discontinued.

Review of Resident 4's chart on 06/14/2024, did not show documentation that the AFH contacted the HCP regarding the refill of Resident 4's Clonazepam.

Observation, on 06/14/2024 at 1:18 PM, showed Resident 4's medication supply did not contain Clonazepam.

In an interview, on 06/24/2024 at 2:58 PM, Collateral Contact 1 (CC1) (pharmacy technician) stated that they had no record on file to discontinue Resident 4's Clonazepam. CC1 stated that they last refilled the Clonazepam in September of 2023. CC1 stated that Resident 4's HCP did not respond to multiple requests to refill the Clonazepam order.

In an interview, on 07/16/2024 at 1:12 PM, CC1 stated that they notified Resident 4's HCP by fax on 10/16/2023 that there were no refills left for Clonazepam. CC1 stated that they notified Resident 4's HCP and the AFH that there were no refills left for Clonazepam by phone on 10/23/2023. CC1 stated that on 10/23/2023, they sent a written notice to the AFH that Resident 4 did not have any refills of Clonazepam left.

Review of Resident 4's home visit summary from their HCP, dated 03/14/2023, showed that Resident 4 had an order for Eucerin lotion (a lotion used to relieve dry skin) applied twice daily.

Observation, on 06/14/2024 at 1:18 PM, showed Resident 4's medication supply did not contain Eucerin lotion.

In an interview, on 06/14/2024 at 12:50 PM, Staff B reported that they could not remember when they ran out of Resident 4's Eucerin lotion. Staff B stated they did not know if they assisted Resident 4 with their prescribed Eucerin lotion when they last initialed Resident 4's ML on 06/12/2024.

This is an uncorrected deficiency previously cited on 04/17/2024 and 02/16/2024.

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, Maple Park Adult Family Home LLC 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 388-76-10475 Medication Log. The adult family home must:

(1) Keep an up-to-date daily medication log for each resident except for residents assessed as medication independent with self-administration.

(2) Include in each medication log the:

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

(3) Ensure the medication log includes:

(c) Documentation of any changes or new prescribed medications including:

(i) The change;

(ii) The date of the change;

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure the medication log (ML) for 4 of 5 residents (Residents 1, 3, 4 & 5) was up to date, included all prescribed medications, and included documentation of the date of medication changes. These failures resulted in inaccurate medication logs and placed Residents 1, 3, 4, & 5 at risk for harm and medication errors.

Findings included…

Resident 1
Record review showed the AFH admitted Resident 1 on [redacted]/2023. Review of Resident 1's assessment, dated 12/01/2023, showed Resident 1 required caregiver assistance with medications.

In an interview, on 06/14/2024 at 12:50 PM, Staff B (Resident Manager) stated that the pharmacy printed the wrong dates on Resident 1's June 2024 ML. Staff B stated that they did not notice the June 2024 ML had the printed dates of 02/01/2024-02/31/2024.

Record review of Resident 1's After Visit Summary (AVS) from their Health Care Provider (HCP) office visit, dated 04/23/2024, showed that Resident 1 had an order for Phenytoin (a medication used to treat uncontrolled movements) 400 milligrams daily.

Record review of Resident 1's June 2024 ML, dated 02/01/2024 – 02/31/2024, showed documentation of Resident 1's Phenytoin dose as 300 milligrams daily. Resident 1's

June 2024 ML showed the caregiver did not document for the administration of Phenytoin to Resident 1 on 06/13/2024.

Observation on 06/14/2024 at 12:23 PM, showed Resident 1's medication supply contained Phenytoin 400 milligrams.

In an interview, on 06/14/2024 at 12:50 PM, Staff B stated that Resident 1 got their prescribed Phenytoin dose of 400 milligrams from 06/01/2024 through 06/13/2024. Staff B stated they did not notice Resident 1's June 2024 ML had their Phenytoin dose documented incorrectly as 300 milligrams daily instead of their prescribed 400 milligrams daily. Staff B stated they forgot to document their initials that they gave Resident 1 their Phenytoin dose on 06/13/2024.

Record review of Resident 1's Electronically Transmitted Prescription, dated 06/12/2024, showed that Resident 1 had an order to decrease Divalproex (a medication used to treat uncontrolled movements) from 250 milligrams twice daily to 250 milligrams once daily at bedtime for two weeks, then discontinue.

Record review of Resident 1's June 2024 ML, dated 02/01/2024 – 02/31/2024, showed documentation of Resident 1's Divalproex dose as 250 milligrams twice daily. The ML showed a handwritten quantity change to one tablet scribbled over the typed quantity of tablets to be administered. Resident 1's June 2024 ML did not show documentation of the date the medication dose was changed for Resident 1's Divalproex. Resident 1's June 2024 ML showed the caregiver did not document for the administration of Divalproex on 06/13/2024 at 8:00 PM.

In an interview, on 06/14/2024 at 12:50 PM, Staff B stated that Resident 1's HCP's office notified the AFH on 06/13/2024 in the afternoon about Resident 1's Divalproex dose decrease to 250 milligrams once daily at bedtime. Staff B stated that they began Resident 1's prescribed Divalproex decrease of 250 milligrams once daily at bedtime as of 06/14/2024. Staff B stated they changed Resident 1's Divalproex quantity to one tablet on their June 2024 ML. Staff B stated they forgot to change Resident 1's Divalproex frequency to once daily instead of twice daily and forgot to document the date of the medication change. Staff B stated they forgot to document their initials that they administered Resident 1 the 8:00 PM Divalproex dose on 06/13/2024.

Record review of Resident 1's June 2024 ML, dated 02/01/2024 – 02/31/2024, showed that the caregiver did not document the administration of the following prescribed medications for Resident 1.

- Amantadine (a medication used to treat uncontrolled movements) 200 milligrams twice daily-missing initials for the 8:00 PM dose on 06/11/2024 through 06/13/2024 and the 8:00 AM dose on 06/13/2024 and 06/14/2024.
- Gabapentin (a medication used to treat nerve pain) 400 milligrams twice daily-missing initials for the 8:00 PM dose on 06/13/2024 and the 8:00 AM dose on

06/13/2024 and 06/14/2024.
- Metformin (a medication used to help regulate blood sugar) 500 milligrams twice daily-missing initials for the 5:00 PM dose on 06/13/2024 and the 8:00 AM dose on 06/13/2024 and 06/14/2024.
- Mirtazapine (a medication used to help increase mood) 7.5 milligrams nightly-missing initials on 06/13/2024.
- Multivitamin daily-missing initials on 06/13/2024 and 06/14/2024.
- Senna (a medication used to regulate bowels) 8.6 milligrams twice daily-missing initials for the 8:00 PM dose on 06/13/2024 and the 8:00 AM dose on 06/13/2024 and 06/14/2024.
- Sertraline (a medication used to help increase mood) 25 milligrams daily-missing initials on 06/13/2024 and 06/14/2024.
- Ketoconazole (a medicated shampoo used to relieve flaking, scaling and itching scalp) two percent shampoo to be used twice weekly-missing initials 06/01/2024 through 06/13/2024.

Record review of Resident 1's AVS from their HCP, dated 04/23/2024, showed that Resident 1 had an order for the following as needed medications that were not documented on Resident 1's June 2024 ML:

- Bisacodyl (a medication used to promote a bowel movement)
- Carboxymethylcellulose (a medication used to lubricate eyes)
- Melatonin (a supplement used to aid sleep)
- Tums (a medication used to treat indigestion)

In an interview, on 06/14/2024 at 12:50 PM, Staff B stated Resident 1 did get their medications. Staff B stated they forgot to sign their initials. Staff B stated they did not notice the pharmacy did not print the orders for the Bisacodyl, Carboxymethylcellulose, Melatonin, and Tums.

Resident 3
Record review showed the AFH admitted Resident 3 on [redacted]/2022. Review of Resident 3's assessment, dated 03/07/2023, showed caregivers were required to administer medications to Resident 3.

In an interview, on 06/14/2024 at 12:50 PM, Staff B stated that the pharmacy printed the wrong dates on Resident 3's June 2024 ML. Staff B stated that they did not notice the June 2024 ML had the printed dates of 03/01/2024-03/31/2024.

Record review of Resident 3's June 2024 ML, dated 03/01/2024 – 03/31/2024, showed that the caregiver did not document the administration of the following prescribed medications for Resident 3.

- Trazadone (a medication used to improve mood) 100 milligrams nightly-missing initials for 06/01/2024 through 06/13/2024.
- Acetaminophen (a medication used treat pain or fever) 1000 milligrams twice daily-missing initials for the 8:00 PM dose on 06/06/2024 through 06/13/2024 and the 8:

00 AM dose on 06/13/2024 and 06/14/2024.
- Sertraline 100 milligrams daily-missing initials on 06/13/2024 and 06/14/2024.
- Senna 8.6 milligrams once daily-missing initials on 06/13/2024 and 06/14/2024.
- Risperidone (a medication used to relieve symptoms of mood disorders) 0.5 milligrams once daily at 2:00 PM and one milligram daily at bedtime-missing initials for the 2:00 PM and bedtime dose on 06/13/2024.
- Mirtazapine 15 milligrams daily at bedtime-missing initials for 06/13/2024.
- Polyethylene Glycol powder (a medication used to help bowel regularity) one scoop daily-missing initials on 06/13/2024 and 06/14/2024.
- Lansoprazole (a medication used to reduce stomach acids) 15 milligrams daily-missing initials on 06/13/2024 and 06/14/2024.

In an interview, on 06/14/2024 at 12:50 PM, Staff B stated Resident 3 did get their medications. Staff B stated they forgot to sign their initials.

Resident 4
Record review showed the AFH admitted Resident 4 on [redacted]/2009. Review of Resident 4's assessment, dated 03/04/2024, showed Resident 4 required caregiver assistance with medications.

Review of Resident 4's home visit summary from their health care provider (HCP), dated 03/14/2023, showed that Resident 4 had an order for Clonazepam (a medicine used to treat anxiety and sudden attacks of panic or fear) 0.5 milligrams once daily at 6:00 PM.

Record review of Resident 4's ML, dated 06/01/2024 – 06/31/2024, showed their order for Clonazepam with a hand-written mark across the date fields that it was discontinued, with no documentation of the date it was discontinued.

In an interview, on 06/14/2024 at 12:50 PM, Staff B stated that the most recent orders they had for Resident 4 was the home visit summary from their HCP dated 03/14/2023. Staff B stated they could not locate the order to discontinue Resident 4's Clonazepam and did not know the date of when it was discontinued.

Review of Resident 4's chart on 06/14/2024, did not show documentation that the AFH contacted the HCP regarding Resident 4's Clonazepam.

Observation, on 06/14/2024 at 1:18 PM, showed Resident 4's medication supply did not contain Clonazepam.

In an interview, on 06/24/2024 at 2:58 PM, Collateral Contact 1 (CC1) (pharmacy technician) stated that they had no record on file to discontinue Resident 4's Clonazepam. CC1 stated that they last refilled the Clonazepam in September of 2023. CC1 stated that Resident 4's HCP did not respond to multiple requests to refill the Clonazepam order.

Record review of Resident 4's May 2024 ML, dated 05/01/2024 – 05/31/2024, showed they had an order for Docusate Sodium (a medication used to soften stool) 100 milligrams twice daily at 8:00 AM and 8:00 PM. Resident 4's May ML showed the caregiver did not document for the administration of Resident 4's 8:00 PM Docusate Sodium dose 05/29/20204 through 05/31/2024.

Record review of Resident 4's June 2024 ML, dated 06/01/2024 – 06/31/2024, showed that the caregiver did not document the administration of the following prescribed medications for Resident 4.

- Docusate Sodium (a medication used to soften stool) 100 milligrams twice daily at 8:00 AM and 8:00 PM-missing initials for the 8:00 PM dose on 06/13/2024 and the 8:00 AM dose 06/13/2024 through 06/14/2024.
- Mirtazapine 15 milligrams daily at bedtime-missing initials on 06/13/2024.
- Senna 8.6 milligrams daily at bedtime-missing initials on 06/13/2024.
- Sertraline 200 milligrams daily at 8:00 AM-missing initials on 06/13/2024 and 06/14/2024.

In an interview, on 06/14/2024 at 12:50 PM, Staff B stated Resident 4 did get their medications. Staff B stated they forgot to sign their initials.

Resident 5
Record review showed the AFH admitted Resident 5 on [redacted]/2024. Review of Resident 5's assessment, dated 03/02/2024, showed Resident 5 required caregiver assistance with medications.

Review of Resident 5's May ML, dated 05/01/2024 – 05/31/2024, showed an order for Melatonin five milligrams daily at bedtime. Resident 5's May 2024 ML showed a handwritten line crossed through all caregiver initials documented for the Melatonin given from 05/01/2024 through 05/20/2024. Resident 5's May 2024 ML showed a handwritten time change for the Melatonin to be given at 5:00 PM instead of 8:00 PM. Resident 5's May 2024 ML did not include documentation of a date the time changed. Resident 5's May 2024 ML showed the caregiver did not document for the administration of Melatonin to Resident 5 from 05/21/2024 through 05/31/2024.

Resident 5's June 2024 ML, dated 06/01/2024 – 06/31/2024, showed the caregiver did not document for the administration of Melatonin to Resident 5 on 06/13/2024.

In an interview, on 06/14/2024 at 12:50 PM, Staff B reported Resident 5's HCP instructed them to change Resident 5's Melatonin dose to 5:00 PM but could not locate any dated documented order for it. Staff B reported Resident 5 did get their Melatonin 05/21/2024 through 05/31/2024, and 06/13/2024. Staff B stated they forgot to document their initials for the Melatonin dose on 05/21/2024 through 05/31/2024 and 06/13/2024.

Record review of Resident 5's June 2024 ML, dated 06/01/2024 – 06/31/2024, showed that the caregiver did not document the administration of the following prescribed medications for Resident 5.

- Acetaminophen 650 milligrams daily at bedtime-missing initials for the dose on 06/13/2024.
- Acidophilus (a supplement that aids in the balance of intestinal bacteria) daily at 8:00 AM-missing initials on 06/13/2024 and 06/14/2024.
- Aspirin (a medication to treat pain, fever, swelling and helps prevent blood clots) 81 milligrams daily at 8:00 AM-missing initials on 06/13/2024 and 06/14/2024.
- Levothyroxine (a medicine used to treat an underactive thyroid gland) 25 micrograms daily at 8:00 AM-missing initials on 06/13/2024 and 06/14/2024.
- Myrbetriq (a medication used to treat overactive bladder) 50 milligrams daily at 8:00 AM-missing initials on 06/13/2024 and 06/14/2024.
- Nuplazid (a medication used to treat hallucinations and delusions) 34 milligrams daily at 8:00 AM-missing initials on 06/13/2024 and 06/14/2024.
- Senna 8.6 milligrams daily at 8:00 PM-missing initials on 06/13/2024.
- Sertraline 150 milligrams daily at 8:00 AM-missing initials on 06/13/2024 and 06/14/2024.
- Multivitamin daily at 8:00 AM-missing initials on 06/13/2024 and 06/14/2024.
- Trazadone 100 milligrams daily at 8:00 PM-missing initials on 06/13/2024.
- Vitamin B-1 100 milligrams daily at 8:00 AM- missing initials on 06/13/2024 and 06/14/2024.
- Oxcarbazepine (a medication used to treat uncontrolled body movements) 450 milligrams twice daily at 8:00 AM and 5:00 PM-missing initials for the 5:00 PM dose on 06/13/2024 and the 8:00 AM dose 06/13/2024 through 06/14/2024.
- Rivastigmine (a medication used to treat confusion from other mental disorders) six milligrams twice daily at 8:00 AM and 5:00 PM-missing initials for the 5:00 PM dose on 06/13/2024 and the 8:00 AM dose 06/13/2024 through 06/14/2024.
- Carbidopa-Levodopa (a medicine to manage unintended movements) 25-100 milligrams four times daily at 8:00 AM, 12:00 PM, 5:00 PM and 8:00 PM-missing initials on 06/13/2024 for all scheduled doses and the 8:00 AM dose on 06/14/2024.

In an interview, on 06/14/2024 at 12:50 PM, Staff B stated Resident 5 did get their medications. Staff B stated they forgot to sign their initials.

This is an uncorrected deficiency previously cited on 04/17/2024 and 02/16/2024.

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, Maple Park Adult Family Home LLC 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

3906-172nd St NE, Suite #100, Arlington, WA 98223

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 04/16/2024 and 04/16/2024 of:

Maple Park Adult Family Home LLC
319 S PARK ST
LYNDEN, WA 98264

This document references the following SOD dated: 04/17/2024

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

The department staff that inspected the Adult Family Home:

Jennifer Nichols, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

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

(d) Receives medications as required.

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to administer medications as required for 1 of 5 residents (Resident 5). This failure resulted in Resident 5 not receiving all prescribed medications and placed them at risk for medical complications and increased pain.

Findings included…

Record review showed the AFH admitted Resident 5 on [redacted]/2024 with multiple diagnoses that included [redacted] and [redacted]. Review of Resident 5's assessment, dated 03/02/2024, showed Resident 5 required caregiver assistance with medications.

Review of Resident 5's After Visit Summary from their hospital stay, dated [redacted]/2024, showed that Resident 5 had an order for Levothyroxine (a medicine used to treat an underactive thyroid gland) 25 micrograms to be given once daily.

Record review of Resident 5's medication log (ML), dated 03/01/2024 – 03/31/2024, showed no documentation of Resident 5's ordered Levothyroxine.

In an interview, on 04/16/2024 at 2:00 PM, Staff A (Entity Representative) stated that Resident 5 did not receive their ordered Levothyroxine 03/05/2024 through 03/31/2024 because they did not get this medicine from the family until 04/01/2024. Staff A stated the AFH's pharmacy would not provide Resident 5's Levothyroxine from 03/05/2024 through 03/31/2024 until the AFH's pharmacy received a written order for it from Resident 5's health care provider.

Record review of Resident 5's record showed no documentation to support the AFH's pharmacy not sending Resident 5's Levothyroxine from 03/05/2024 through 03/31/2024 due to needing a written order from Resident 5's health care provider.

Review of Resident 5's After Visit Summary from their hospital stay, dated [redacted]/2024, showed that Resident 5 had an order for Diclofenac (a pain-relieving ointment) one percent gel with two grams to be applied four times daily. Review of Resident 5's medication list from their health care provider, dated 03/21/2024, showed that the Diclofenac one percent gel was no longer ordered for Resident 5.

Record review of Resident 5's ML, dated 03/01/2024 – 03/31/2024, showed Resident 5's Diclofenac one percent gel was discontinued on 03/19/2024 at the 4:00 PM dose instead of being discontinued per Resident 5's health care provider order on 03/21/2024.

In an interview, on 04/16/2024 at 2:00 PM, Staff A stated that they discontinued Resident 5's Diclofenac one percent gel on 03/19/2024 based on Resident 5's health care provider's direction but could not get the documentation for it from them despite multiple attempts. Staff A stated they should have made sure they had documentation of the change from the health care provider before implementing it.

This is an uncorrected deficiency previously cited on 03/01/2024.

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, Maple Park Adult Family Home LLC 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 388-76-10475 Medication Log. The adult family home must:

(1) Keep an up-to-date daily medication log for each resident except for residents assessed as medication independent with self-administration.

(2) Include in each medication log the:

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

(3) Ensure the medication log includes:

(c) Documentation of any changes or new prescribed medications including:

(i) The change;

(ii) The date of the change;

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure the medication log for 3 of 5 residents (Residents 1, 4 & 5) was up to date, included all prescribed medications, and documentation of medication changes. These failures placed Residents 1, 4 & 5 at risk for harm and medication errors.

Findings included…

Resident 1

Record review showed the AFH admitted Resident 1 on [redacted]/2023. Review of Resident 1's assessment, dated 12/01/2023, showed Resident 1 required caregiver assistance with medications.

Record review of Resident 1's After Visit Summary (AVS) from their health care provider, dated 03/14/2024, showed that Resident 1 had an order to increase the dose of Phenytoin (a medication used to treat uncontrolled movements) from 300 milligrams daily to 400 milligrams daily.

Record review of Resident 1's ML, dated 03/01/2024 – 03/31/2024, showed no documentation of Resident 1's Phenytoin dose change from 300 milligrams daily to 400 milligrams daily from 03/14/2024 through 03/31/2024.

In an interview, on 04/16/2024 at 2:00 PM, Staff A (Entity Representative) stated that Resident 1 got their increased Phenytoin dose of 400 milligrams from 03/14/2024 through 03/31/2024. Staff A stated they were in a hurry and missed updating Resident 1's ML to include Resident 1's increased Phenytoin dose from 300 milligrams daily to 400 milligrams daily starting on 03/14/2024.

Resident 4

Record review showed the AFH admitted Resident 4 on [redacted]/2009. Review of Resident 4's assessment, dated 03/04/2024, showed Resident 4 required caregiver assistance with medications.

Review of Resident 4's Electronically Transmitted Prescription, dated 02/22/2024, showed that Resident 4 was prescribed Mupirocin (a medicine to treat skin infections) two percent External Ointment to be applied twice daily as needed to affected skin sores.

Record review of Resident 4's ML, dated 03/01/2024 - 03/31/2024, showed no documentation of Resident 4's Mupirocin prescribed on 02/22/2024.

In an interview, on 04/16/2024 at 2:00 PM, Staff A stated that they did not update Resident 4's ML, dated 03/01/2024 – 03/31/2024, to include Resident 4's Mupirocin prescribed on 02/22/2024 because they were in a hurry and too busy.

Resident 5

Record review showed the AFH admitted Resident 5 on [redacted]/2024. Review of Resident 5's assessment, dated 03/02/2024, showed Resident 5 required caregiver assistance with medications.

Review of Resident 5's AVS from their hospital stay, dated [redacted]/2024, showed that Resident 5 was prescribed Carbidopa-Levodopa (a medicine to manage unintended movements) 25-100 milligrams two tablets with breakfast, one tablet with lunch, one tablet with dinner and one tablet at bedtime. The AVS showed the Carbidopa-Levodopa was ordered to start on 03/05/2024.

Record review of Resident 5's ML, dated 03/01/2024 – 03/31/2024, showed Resident 5's Carbidopa-Levodopa 25-100 milligrams had AFH staff initials on 03/04/2024 at dinner and bedtime doses indicating Resident 5 was given their Carbidopa-Levodopa before it was supposed to be started on 03/05/2024.

In an interview, on 04/16/2024 at 2:00 PM, Staff A stated that they signed Resident 5's ML, dated 03/01/2024 – 03/31/2024, in error for Resident 5's dinner and bedtime doses of Carbidopa-Levodopa on 03/04/2024 because they did not give it to Resident 5 until 03/05/2024.

Review of Resident 5's (AVS) from their hospital stay, dated [redacted]/2024, showed that Resident 5 had an order for Levothyroxine (a medicine used to treat an underactive thyroid gland) 25 micrograms to be given once daily.

Record review of Resident 5's ML, dated 03/01/2024 – 03/31/2024, showed no documentation of Resident 5's ordered Levothyroxine.

In an interview, on 04/16/2024 at 2:00 PM, Staff A stated that they did not document Resident 5's Levothyroxine order on Resident 5's ML, dated 03/01/2024 – 03/31/2024, because they did not get this medicine from the family until 04/01/2024.

This is an uncorrected deficiency previously cited on 03/01/2024.

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, Maple Park Adult Family Home LLC 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
3906-172nd St NE, Suite #100, Arlington, WA 98223

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 02/15/2024 and 02/15/2024 of:

Maple Park Adult Family Home LLC
319 S PARK ST
LYNDEN, WA 98264

This document references the following complaint number(s): 117293

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

The department staff that investigated the Adult Family Home:

Jennifer Nichols, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

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

(d) Receives medications as required.

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to administer medications as required for 1 of 4 residents (Resident 1). This failure placed Resident 1 at risk of sudden uncontrolled movements due to incorrect doses administered.

Findings included…

Record review showed the AFH admitted Resident 1 on [redacted]/2023 with multiple diagnoses that included [redacted] and [redacted]. Review of Resident 1's assessment, dated 12/01/2023, showed Resident 1 required caregiver assistance with medications.

Record review of Resident 1's After Visit Summary from their health care provider office visit, dated 12/27/2023, showed that Resident 1 had an order for Amantadine (a medication used to treat uncontrolled movements) 200 milligrams to be given twice daily and Divalproex (a medication used to treat Epilepsy) 750 milligrams to be given twice daily.

Record review of Resident 1's medication log (ML), dated December 2023, showed Staff C (former Caregiver) initialed indicating they gave Resident 1 Amantadine 100 milligrams instead of the ordered 200 milligrams twice daily 12/27/2023 through 12/30/2023. Resident 1's ML, dated December 2023, showed Staff C initialed the ML indicating they gave Resident 1 Divalproex 250 milligrams three times a day instead of the ordered 750 milligrams twice daily 12/27/2023 through 12/30/2023.

Record review of Resident 1's ML, dated January 2024, showed Staff C initialed indicating they gave Resident 1 Amantadine 100 milligrams twice daily instead of the ordered 200 milligrams twice daily 01/01/2024 through 01/28/2024. Resident 1's ML, dated January 2024, showed Staff C initialed the ML indicating they gave Resident 1 Divalproex 250 milligrams three times a day instead of the ordered 750 milligrams twice daily 01/01/2024 through 01/28/2024.

In an interview, on 02/15/2024 at 12:00 PM, Staff B (Resident Manager) stated that they "don't know why" they did not give Resident 1 the new dose changes for Amantadine and Divalproex from 12/27/2023 through 01/28/2024.

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, Maple Park Adult Family Home LLC 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 388-76-10475 Medication Log. The adult family home must:

(1) Keep an up-to-date daily medication log for each resident except for residents assessed as medication independent with self-administration.

(2) Include in each medication log the:

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

(3) Ensure the medication log includes:

(c) Documentation of any changes or new prescribed medications including:

(i) The change;

(ii) The date of the change;

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure the medication log for 1 of 4 residents (Resident 1) was up to date, included all prescribed medications and included documentation of medication changes. This failure resulted in Resident 1 receiving incorrect dosages of medications and placed them at risk for harm and further medication errors.

Findings included…

Record review showed the AFH admitted Resident 1 on [redacted]/2023 with multiple diagnoses that included [redacted] and [redacted]. Review of Resident 1's assessment, dated 12/01/2023, showed Resident 1 required caregiver assistance with

medications.

Record review of Resident 1's medication log (ML), dated December 2023, showed that the date of 12/31/2023 was missing from the ML. The ML had no documentation to indicate that staff gave medications to Resident 1 on 12/31/2023.

In an interview, on 02/15/2024 at 12:00 PM, Staff B (Resident Manager) stated that Resident 1 "probably" got their prescribed medication on 12/31/2024 but did not know why Resident 1's ML was not up to date.

Record review of Resident 1's After Visit Summary from their health care provider office visit, dated 12/27/2023, showed the following changes to Resident 1's medications:

- Amantadine (a medication used to treat uncontrolled movements) increased from 100 milligrams to 200 milligrams twice daily.

- Divalproex (a medication used to treat Epilepsy) changed from 250 milligrams three times a day to 750 milligrams twice daily.

Record review of Resident 1's ML, dated December 2023, showed no documentation of Resident 1's dosage changes for Amantadine or Divalproex from 12/27/2023 through 12/30/2023.

Record review of Resident 1's ML, dated January 2024, showed no documentation of Resident 1's dosage changes for Amantadine or Divalproex from 01/01/2024 through 01/28/2024.

In an interview, on 02/15/2024 at 12:00 PM, Staff B stated that they did not know why Resident 1's dosage changes for Amantadine or Divalproex from 12/27/2023 were not documented on Resident 1's December 2023 or January 2024 MLs.

Record review of Resident 1's After Visit Summary from their health care provider office visit, dated 12/27/2023, showed that Resident 1 was prescribed Ketoconazole (a medication used to treat skin infections caused by fungus) two percent shampoo to be applied twice weekly.

Record review of Resident 1's ML, dated December 2023, showed no documentation of Resident 1's prescribed order for Ketoconazole.

Record review of Resident 1's ML, dated January 2024, showed no documentation of Resident 1's prescribed order for Ketoconazole.

Record review of Resident 1's After Visit Summary from a hospital stay, dated [redacted]/2024 – [redacted]/2024, showed that Resident 1 was prescribed the following medications upon discharge back to the AFH on [redacted]/2024:

- Acetaminophen (a medication used to treat pain or fever) 650 milligrams every six hours as needed

- Bisacodyl (a medication used to regulate bowels) 10 milligrams daily as needed

- Carboxymethylcellulose (a medication used to treat dry eyes) 0.5 percent eye drop to both eyes every two hours as needed

- Ketoconazole two percent shampoo applied twice weekly

- Melatonin (a supplement used to aid sleep) three milligrams nightly as needed

- Ondansetron (a medication used to relieve the urge to vomit) four milligrams every eight hours as needed

- Tums (a medication used to relieve indigestion) 500 milligrams three times daily as needed

Record review of Resident 1's ML, dated 02/01/2024 – 02/31/2024, showed no documentation of Resident 1's prescribed orders for Acetaminophen, Bisacodyl, Carboxymethylcellulose, Ketoconazole, Melatonin, Ondansetron or Tums.

In an interview, on 02/15/2024 at 12:20 PM, Staff A (Entity Representative) stated that they still needed to write all the prescribed orders from 02/02/2024 for Resident 1 on their ML because the pharmacy did not print them out.

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, Maple Park Adult Family Home LLC 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 _____