STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave, Suite 200, Vancouver, WA 98684

Tag-A-Long Home Care LLC
Tag-A-Long Care Home LLC
11412 NE Conifer Dr
Vancouver, WA 98662

RE: Tag-A-Long Care Home LLC License # 755824

Dear Provider:

This letter addresses Compliance Determination(s) 47326 (Completion Date 09/17/2024) and 44631 (Completion Date 08/22/2024).

The Department completed a follow-up inspection of your Adult Family Home on 09/17/2024 and found that you have corrected the violations listed in the Complaint report dated 08/22/2024. Your home is back in compliance as of 08/23/2024 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 388-76-10400-3-b, WAC 388-76-10225-1-b-iii

The Department staff who did the on-site verification:
Priscilla Changa, Nursing Home Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit F
Residential Care Services

STATE OF WASHINGTON
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800 NE 136th Ave, Suite 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 755824	Compliance Determination # 44631
Plan of Correction	Tag-A-Long Care Home LLC	Completion Date
Page 1 of 5	Licensee: Tag-A-Long Home Care LLC	08/22/2024

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 an unannounced on-site complaint investigation on 07/24/2024 and 08/16/2024 of:

Tag-A-Long Care Home LLC
11412 NE Conifer Dr
Vancouver, WA 98662

This document references the following complaint number(s): 139784, 142994

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

The department staff that investigated the Adult Family Home:

Priscilla Changa, Nursing Home Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit F
800 NE 136th Ave, Suite 200
Vancouver, WA 98684

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

08/26/2024
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.

Aurita E Tagle
Provider (or Representative)

sept 03 2024
Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

(3) The care and services in a manner and in an environment that:

(b) Actively supports the safety of each resident; and

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home failed to develop a safety plan and monitor safety for 2 of 2 sampled resident (Resident 1/R1 and Resident 2/R2). This failure placed R1 and R2 at risk of medical complications, unmet needs and potential harm.

Findings included...

<Resident 1>

Record review of R1's assessment, dated 06/03/2024 showed R1 was diagnosed with [redacted]. The record showed R1 was cognitively impaired and had a court appointed legal guardian in place. The record showed that the resident exhibited wandering and exit seeking behaviors, with multiple reports of them going outside, leading to instances where they went missing and were subsequently returned by the police. The record showed R1 needed one on one supervision for safety. The record instructed staff to supervise R1 when outside and/or take a walk with the resident.

Record review of R1's negotiated care plan, dated 06/28/2024 documented that R1 exhibited wandering and exit-seeking behaviors, and was permitted to go outside independently. The record directed staff to enable R1 to go outdoors while reminding R1 to avoid getting lost. The record instructed staff to "not intervene if client decides to go for a walk, allow client to go outside at their own will." The record highlighted the need for a "more detailed safety plan" and lacked the legal guardian's signature.

Record review of R1's progress note dated 07/22/2024 showed that R1 was absent from 5:00 PM, and the staff had reminded R1 to return home. The record also noted that the staff waited until 5:00 AM for R1's return. The record showed the police and guardian were notified on 07/23/2024.

During an interview on 07/24/2024 at 09:59 AM, Staff B, Caregiver, said that R1 was independent in the community and frequently visited the gas station almost every day on their own.

During an interview on 07/24/2024 at 10:37 AM, Staff A, Provider reported that on [redacted]/2024, approximately at 4:30 PM, R1 left alone for the gas station and did not come back. Staff A said that they searched for R1 but were unsuccessful. They decided to notify the police the following day when R1 failed to return. R1's guardian was notified on [redacted]/2024 at approximately 2:00 PM. Staff A reported that the notification to the guardian was not made in a timely manner because the guardian's offices were closed and they were still waiting for R1 to return. Staff A reported that R1 was independent within the neighborhood. According to Staff A, the resident was permitted to visit the gas station alone as it was included in their care plan. Staff A reported that R1's guardian disagreed with R1 visiting the gas station unaccompanied, returned the negotiated care plan unsigned, and requested a revision of the care plan to include a more detailed safety plan. Staff A reported that they had not created a safety plan and were unable to supervise the resident due to insufficient funding for hiring additional caregivers. Staff A was unaware of R1's location.

Record review of an email received by the Department, on 07/25/2024 at 3:19 PM, from Collateral Contact 1, Case Manager showed that R1 required supervision as there were at risk of getting lost in the community.

During an interview on 08/15/2024 at 10:48 AM, Collateral Contact 1(CC1), Guardian, reported several instances of R1 leaving the home unsupervised, becoming lost, and subsequently being returned to the residence. CC1 reported that R1 needed to be supervised when outdoors, and R1 was unaccounted for roughly 42 hours. CC1 stated that on [redacted]/2024, at approximately 2:00 PM, they were alerted by the provider that R1 had been missing since [redacted]/2024 from 5:00 PM. CC1 stated that they were not immediately informed when R1 was discovered missing, and the police were not notified until the following day. CC1 reported that the provider allowed R1 to go to the gas station alone, which was not previously agreed upon. CC1 reported that they had reviewed R1's negotiated care plan and had returned it unsigned, requesting a more comprehensive safety plan given R1's status as a safety risk. CC1 noted that a safety plan was not created following their request.

During an interview on 08/16/2024 at 11:05 PM, R1 said they went to the gas station alone and did not return to home. R1 said they went to the gas station unsupervised daily to purchase a Slurpee. R1 said they met someone who offered them a ride home.

During an interview on 08/16/2024 at 12:21 PM Staff A reported they expected R1 to return home by approximately 10:00 PM. Staff A indicated that they should have informed the police and guardian when R1 failed to return home by the expected time.

<Resident 2>

Record review of R2's assessment, dated 04/11/2024 showed R2 had a diagnosis of [redacted]

Record review of R2's negotiated care plan, dated 10/09/2019 showed R2 was admitted to the home on [redacted]/2019. The record did not show instructions for staff on what to do when R2 had a seizure. The record was not updated and was unsigned by R2's legal representative and the provider.

Record review of R2's progress notes, dated 05/02/2024 showed R2 experienced a seizure while in bed.

During an interview on 08/16/2024 at 11:30 AM, Staff A, reported that on 06/27/2024, R2 experienced three seizures at home and was subsequently transported to the hospital.

During an interview on 08/22/2024 at 2:55 PM Staff A said that a safety plan was not included due to R2 not experiencing seizures in the home. Staff A reported that R2 had informed them of experiencing a seizure early this year. Staff A said that they "missed to include a seizure care plan" and are currently revising R2's care plan, which will be sent to R2's guardian for a signature. Staff A indicated that a safety plan should have been established.

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, Tag-A-Long Care Home LLC is or will be in compliance with this law and / or regulation on (Date) 8/23/24.

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

Provider (or Representative) 8-27-24 Date

WAC 388-76-10225 Reporting requirement.

(1) The adult family home must ensure all staff:

(b) Report the following to the department by calling the complaint toll-free hotline number:

(iii) A missing resident.

This requirement was not met as evidenced by:

Based on interview and record review the home failed to report to the Department that facility staff were unable to locate R1 and was determined missing, for one of one sampled Resident (Resident1/R1). This failure to report to CRU prevented The Department from being able to evaluate systems that were in place to protect residents.

Findings included...

Record review of R1's assessment, dated 06/03/2024 showed R1 was diagnosed with [redacted]. The record showed R1 was cognitively (thought) impaired and exhibited wandering and exit-seeking behaviors.

During an interview on 07/24/2024 at 10:37 AM, Staff A, Provider, reported that on [redacted]/2024, approximately at 4:30 PM, R1 left the home, alone, for the gas station and did not come back. Staff A said that they searched for R1 but were unsuccessful. Staff A reported they determined R1 was missing when they did not return to the home the next day. Staff A said that they failed to report to CRU because they had forgotten. Staff A indicated they should have reported.

Record review of The Department's reporting and tracking system showed the provider had not reported that R1 was missing.

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, Tag-A-Long Care Home LLC is or will be in compliance with this law and / or regulation on (Date) 8/23/24.

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

Provider (or Representative) 8-29-24 Date

TAG-A-LONG HOME CARE LLC AUG 27 2024

LICENSE # 755824

PLAN OF CORRECTION

Regarding the deficiency resulting from complaint numbers 139784, 142994. TAG-A-LONG HOME CARE LLC has completed the following:

Immediately implemented: WAC 388-76-10400 & 388-7610225

Resident 1: Clients care plan has been revised 8/22/2024, it now includes a detailed plan for outside supervision. The client will be visually supervised while on the property and if client wishes to leave property staff will attempt to redirect him if the staff is unable to chaperone at that time. Staff will attempt to schedule a time when they are available, if client cannot be redirected then staff will notify client that should he leave without chaperone then facility will be required to call the 800 hotline and report his elopement as well as his guardian. Staff should use every means available to redirect the client back to the facility. Staff have been updated on mandatory reporting and contacting emergency services policies.

Resident 2: Clients plan of care was revised on 08/22/2024 to include following the policy and procedure for contacting emergency services. In this policy any medical emergency including seizures will be followed with immediate call to 911, unless a written doctors order is available that supersedes this directive. Staff have been updated on mandatory reporting and contacting emergency services policies.

SYSTEM TO INCLUDE CONTINUED COMPLIANCE: WAC 388-76-10400 & 388-7610225

Resident 1: Staff have been directed to review and follow all clients care plans & policies regarding mandated reporting and contacting emergency services, as written with no deviations. Staff will additionally review care plans after any updates or revisions and annually after review. Additional this client has improved his mental state considerably over the previous 2 months (since being out of the hospital). This client was also noted as being in a extremely "drugged state after his monthly injections for the first week, before he became coherent again. His medicine dosage was reduced per doctors' orders, and he seems very much more coherent. We will recommend he be re-evaluated for his mental competency; this client feels he is capable and coherent of travelling on foot locally. However, until, if, or when his evaluation changes the strict safety protocol will remain. This client's care plan has been sent to the case manager for signature and will subsequently be sent to the guardian for signature.

Resident 2: This client was moved out of this facility after notification from Guardian received on 8/21/2024 and physically moved on [redacted]/2024 at 10:30 am. However, had she remained in this facility the policy and procedure for contacting emergency services and mandated reporting would ensure her safety when experiencing seizures.

SIGNED: _____ DATE 8-27-24

PRINT Amrita Tagle