STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Eternal Life Adult Family Home LLC
Eternal Life Adult Family Home
3713 W Sylvester St
Pasco, WA 99301

RE: Eternal Life Adult Family Home License # 755911

Dear Provider:

This letter addresses Compliance Determination(s) 35162 (Completion Date 01/12/2024) and 30116 (Completion Date 11/13/2023).

The Department completed a follow-up inspection of your Adult Family Home on 01/12/2024 and found that you have corrected the violations listed in the Complaint report dated 11/13/2023. Your home is back in compliance as of 12/28/2023 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10315-1-h, WAC 388-76-10315-1-b, WAC 388-76-10315-2, WAC 388-76-10315-1-g, WAC 388-76-10315-1-a, WAC 388-76-10330-1, WAC 388-76-10330-2, WAC 388-76-10355-1, WAC 388-76-10355-2, WAC 388-76-10355-3, WAC 388-76-10355-7-a, WAC 388-76-10355-10, WAC 388-76-10355-8, WAC 388-76-10355-7-b, WAC 388-76-10355-6-b, WAC 388-76-10430-1, WAC 388-76-10430-2-c, WAC 388-76-10430-2-d, WAC 388-76-10430-3

The Department staff who did the on-site verification:
Jo Whitney, AFH Licensor

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, Field Manager

Region 1, Unit C
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Eternal Life Adult Family Home
License/Cert.#: 755911
Compliance Determination #: 30116
Investigator: Jo Whitney
Provider Type: Adult Family Home
Intake ID: 98532
Region/Unit #: RCS Region 1 / Unit C
Investigation Date(s): 09/28/2023 through 11/13/2023
Complainant Contact Date(s): 09/26/2023, 10/13/2023, 10/30/2023

Allegation(s):

1) Named Resident (NR) was not getting medication ordered for them by the emergency room (ER). The medication was not delivered to the home or picked up when needed.
2) The Provider was not responding to the representative's questions about the NR.
3) The adult family home (AFH) turned away visitors.
4) Named Resident was not assisted with toileting when needed at night.
5) NR developed skin breakdown due to incontinent product usage.

Investigation Methods:

Sample:	Total residents: 3 Resident sample size: 3 Closed records sample size: 0
Observations:	Home environment for safety and quality of life, resident rooms, common areas, staff to resident interactions, medication assistance, provision of care, skin condition
Interviews:	Provider, resident, collateral contacts
Record Reviews:	Resident records including assessment, negotiated care plan (NCP), medication log, prescriber orders, hospital records, admission agreement, Disclosure of Services, employee qualifications

Investigation Summary:

1) Medication delivery to the home was the responsibility of the Resident Representative. New orders and needed refills could be picked up if coordinated with the Provider. Unable to verify medication was given as ordered; failed practice identified related to the lack of a system of medication management that included the creation of a medication log showing what was prescribed and what was given.
2) The Provider was the caregiver in the AFH for three residents. Alternate means of communication was accepted and coordinated with the Provider and Resident Representative when they were unable to answer the phone. No failed practice identified.
3) The Provider was the caregiver in the AFH for three residents; if providing care was

unable to answer the door. A visitor log was initiated; contacted visitors stated they were not denied access.
4) Unable to verify allegation. Named Resident denied lack of staff assistance when needed.
5) Named Resident with incontinence provided incontinent product (brief) for dignity. Named Resident declined to use. Named Resident declined/refused assistance with personal hygiene. Reddened area found during emergency exam – interventions followed to cleanse and promote healthy skin. Issue resolved, no other concerns for resident skin integrity.

Conclusion / Action:

- ☐ Failed Provider Practice Identified / Citation(s) Written
- ☒ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 755911	Compliance Determination # 30116
Plan of Correction	Eternal Life Adult Family Home	Completion Date
Page 1 of 10	Licensee: Eternal Life Adult Family Home LLC	11/13/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 09/28/2023, 10/12/2023 and 10/12/2023 of:

Eternal Life Adult Family Home
3713 W Sylvester St
Pasco, WA 99301

This document references the following complaint number(s): 98532

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

The department staff that investigated the Adult Family Home:

Jo Whitney, AFH Licensor
Tamera Lapierre, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit C
1200 Alder Street
Union Gap, WA 98903

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.

Michelle Closner
Residential Care Services

11/21/2023
Date

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative)

12/01/2023
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:

(a) Contain enough information so home can provide the needed care and services to each resident;

(b) Be in a format useful to the home;

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

(h) Provide access to the resident to review their record and obtain copies of their record at a reasonable cost.

(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 interview and record review, the Adult Family Home (AFH) failed to have records in the AFH for 2 of 3 residents (Resident 1 & 2) and failed to provide resident records for 1 of 3 residents (Resident 1) when requested. This failure placed the residents at risk of decreased quality of care, residents' being denied their right of access and negligent care by staff due to staff unable to review required information about resident care.

Findings included...

On 09/28/2023 resident records were reviewed.
Resident 1 admitted to the home on [redacted]/2023. The AFH record did not include an assessment or preliminary service plan.

Resident 2 admitted to the home on [redacted]/2023 and was an emergency admit. The AFH record did not include an assessment or preliminary service plan completed within 5 days of admit.

On 09/28/2023 at 11:00 AM, Staff A, Provider, stated the Collateral Contact (CC1) for Resident 2 had told them about their care needs over the phone before their admit. Staff A stated they contacted Collateral Contact 3 (CC3), Qualified assessor, on [redacted]/2023 to do the assessment for Resident 2 and for Resident 1. CC3 was in the home to do assessments on Resident 1 and Resident 2 on 08/23/2023. Staff A stated CC3 did not leave an assessment or preliminary service plan in the home for Staff A. Staff A stated the care and services they provided were based on their knowledge as a caregiver; they had contacted

CC3 frequently to discuss the care needs of the residents and receive direction. Staff A stated they did not see the assessments until 10/01/2023 when CC3 brought the records to the home per the department's request to review.

On 10/30/2023 at 8:00 AM, CC1 reported they had requested and not received the medication administration record for Resident 1 when at the AFH on 10/27/2023. Interviewed on 11/13/2023 at 2:35 PM, Staff A stated they were not in the home and thought the record was provided.

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, Eternal Life Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 12/28/2023.

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

Juliana Mathis — Provider (or Representative)

12/01/2023 — Date

WAC 388-76-10330 Resident assessment. The adult family home must:

(1) Obtain a written assessment that contains accurate information about the prospective resident's current needs and preferences before admitting a resident to the home;

(2) Not admit a resident without an assessment except in cases of a genuine emergency;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to obtain a written assessment for 1 of 2 residents (Resident 1) prior to admission. This deficient practice placed the resident and staff at risk of harm or injury due to undefined care needs and lack of preparedness to meet the needs.

Findings include...

On 9/28/2023 at 10:40 AM, Staff A, Provider, and Resident 1 were standing at Resident 1's bedside, a walker was nearby but not within reach. Staff A walked side by side with Resident 1 from the bedroom, into the hallway toward the front room. Resident 1 had a hearing aid in their left ear; Staff A had to speak loudly and clearly to be understood by Resident 1. Resident 1 needed hands-on support by Staff A or to grasp the handrail in the hallway to steady themselves. Resident 1 stopped twice during the short walk to a recliner in the front room to "catch" their breath. After sitting less than 5 minutes, Resident 1

requested to return to their room to lie down. Staff A walked with Resident 1 back to the room where they sat on the edge, lay towards the pillow, then lift their own legs onto the bed. Once settled on the bed, Resident 1 turned on the twin size bed to lay on their side. Staff A stated Resident 1 had a wheeled walker but did not use it.

On 09/28/2023 at 11:00 AM, Staff A stated they had known when Resident 1 would move into the AFH (on [redacted]/2023) after talking with Collateral Contact 1 (CC1) on [redacted]/2023. Staff A stated they contacted Collateral Contact 3(CC3), Qualified Assessor, to do Resident 1's assessment on [redacted]/2023. Resident 1 moved into the home on [redacted]/2023 without Staff A reviewing a written assessment. CC3 was not at the AFH to do the initial assessment until 08/23/2023, [redacted] days after Resident 1 admitted into the AFH.

On 10/13/2023 at 11:35 AM, CC3 stated Staff A had contacted them to complete the assessments for two new residents at the AFH. CC3 stated they went to the AFH on Wednesday 08/23/2023 to complete the initial assessment for Resident 1; they did not see them before they admitted to the home on [redacted]/2023. CC3 stated they had "14 days to complete the assessment."

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, Eternal Life Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 12/28/2023.

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

Yuliana Martinez — Provider (or Representative)

12/01/2023 — Date

WAC 388-76-10355 Negotiated care plan. The adult family home must use the resident assessment and preliminary care plan to develop a written negotiated care plan. The home must ensure each resident's negotiated care plan includes:

(1) A list of the care and services to be provided;

(2) Identification of who will provide the care and services;

(3) When and how the care and services will be provided;

(6) Other preferences and choices about issues important to the resident, including, but not limited to:

(b) Daily routine;

(7) If needed, a plan to:

(a) Follow in case of a foreseeable crisis due to a resident's assessed needs;

(b) Reduce tension, agitation and problem behaviors;

(8) Identification of any communication barriers the resident may have and how the home will use behaviors and nonverbal gestures to communicate with the resident;

(10) A hospice care plan if the resident is receiving services for hospice care delivered by a licensed hospice agency.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to develop a Negotiated Care Plan (NCP) identifying assessed or observed needs and staff interventions to meet the specific needs of each resident for 2 of 2 residents (Resident 1 & 2). This failure placed the residents at risk for unmet needs and loss of rights in determining the provision of care and services.

Findings included...

Resident 2.
On 09/28/2023 at 11:00 AM, Staff A, Provider, stated they were contacted by the local hospital for the emergency admission of Resident 2 on [redacted]/2023. Collateral Contact 1 (CC1) had told them about Resident 2's needs over the phone. Staff A contacted Collateral Contact 3 (CC3), Qualified Assessor, to do the assessment. CC3 was in the home to complete the initial assessment on 08/23/2023. On [redacted]/2023, Resident 2 was hospitalized for a condition change, returning to the AFH on [redacted]/2023 on hospice services. A copy of the assessment and preliminary service plan was not in the home on 09/28/2023.

On 09/28/2023 at 10:45 AM, Resident 2 stated they frequently needed help to get in and out of bed and to get up at night to go to the bathroom, and "sometimes did not make it."

In Resident 2's record on 09/28/2023, the AFH had a form titled "Negotiated Service Plan for Activities of Daily Living" with the date of [redacted]/2023 and no resident name. The last page, a signature page for "Preliminary and Negotiated Care Plans" was signed by Staff A and CC1 without a date. Staff A stated they were provided the form with recommended pre-checked boxes. The plan showed a need for moderate assist with personal hygiene but did not show what Resident 2 could do or what staff would assist with. The plan was not marked to show what, when or how the resident needed assistance with dressing, walking (if they used a walker), sleep pattern or bed mobility. Emergency evacuation needs were not shown. The plan did not include the coordination with hospice services.

Resident 1.
Admitted into the AFH on [redacted]/2023 from their home. Their initial assessment was completed on 08/23/2023 by CC3, after Resident 1 had moved into the AFH. A copy of the assessment and preliminary service plan was not in the home on 09/28/2023.

On 09/26/2023, CC1 stated they had talked to Staff A about the emergency admission of Resident 2 on [redacted]/2023 and the planned for Resident 1 to admit to the AFH on [redacted]/2023 because they could not stay alone in their own home. CC1 stated Resident 1 needed help to get to get in/out of the bed and movement in the home because they were legally blind and forgetful. Resident 1 took a blood thinner (warfarin- anticoagulant used to treat and prevent blood clots); they would need transportation to the anticoagulant clinic for blood tests.

On 9/28/2023 at 10:40 AM, Resident 1 was standing at their bedside. Staff A walked side by side with Resident 1 from the bedroom, into the hallway toward the front room. Resident 1 had a hearing aid in the left ear and needed Staff A to face them and speak clearly to understood what was said. Resident 1 needed hands-on support by Staff A or to grasp the handrail in the hallway when they stopped to catch their breath during the short walk from the bedroom to a recliner in the front room. Resident 1 requested to return to their room to lie down after sitting only a short time. Staff A walked Resident 1 back to the room where they sat on the edge of the bed, lay their head toward the pillow, and lifted their legs onto the bed without assistance. Resident 1 the turned themselves on the twin size bed to find a comfortable position while Staff A covered them with a blanket. Resident 1 had a wheeled walker in their room; Staff A stated they did not use it. Staff A stated Resident 1 told them when they needed to go to the bathroom and did not wear incontinent briefs; they did have "accidents."

Interviewed on 09/28/2023 at 11:45 AM, Staff A stated Resident 1 would refuse assistance with their care needs, daily hygiene, showering, or after toileting hygiene. Resident 1 would holler when they wanted assistance and continue to holler until assisted.

In Resident 1's record on 09/28/2023, the AFH had a form titled "Negotiated Service Plan for Activities of Daily Living" with the date of [redacted]/2023 and no resident name. The last page, a signature page for "Preliminary and Negotiated Care Plans" was signed by Staff A and CC1 without a date. The plan showed a need for moderate assist with personal hygiene but did not show what they could do or what staff would assist with. The plan was not marked to show Resident 1's use of hearing aid or their blindness. It did not show what, when or how the resident needed assistance with dressing, walking, sleep pattern or bed mobility. It did not show interventions for care refusal or behaviors. Emergency evacuation needs were not shown. The plan did not include who or how Resident 1 would be transported for blood tests or how to recognize or what to do if Resident 1 had uncontrolled bleeding.

On 09/28/2023 at 4:30 PM, Staff A stated CC1 had signed the forms for Resident 1 and 2 without reading them. Staff A contacted CC1 to keep them informed of what they were doing. Staff A stated Residents 1 and 2 were their first admits and they had not gone over the care plans to describe what each resident needed and what the AFH provided. Staff A stated they did not have the assessments and preliminary service plans for Resident 1 or 2 identifying assessed needs. Staff A provided care based on their knowledge as a caregiver.

Attestation Statement

Statement of Deficiencies	License #: 755911	Compliance Determination # 30116
Plan of Correction	Eternal Life Adult Family Home	Completion Date
Page 7 of 10	Licensee: Eternal Life Adult Family Home LLC	11/13/2023

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, Eternal Life Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 12/28/2023.

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

Provider (or Representative) — Date: 12/01/2023

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.

(3) Records are kept which include a current list of prescribed and over-the-counter medications including name, dosage, frequency and the name and phone number of the practitioner as needed.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to ensure they had a system of medication management that included the creation of a medication log showing what was prescribed and what was given for 3 of 3 residents (Resident 1, 2, 3). The failure placed the residents at risk for medication errors and medical condition mismanagement.

Findings included...

Resident 1.
Admitted into the AFH on [redacted]/2023. The AFH did not have an assessment for Resident 1. The record included a 'Negotiated Service Plan' showing the move-in date of [redacted]/2023. It was marked to show Resident 1 needed assistance with medications. "Log all medications given and consumed by resident." The record included Warfarin (anticoagulant used to treat and prevent blood clots) dosage directions from the Anticoagulation Clinic dated 08/22/2023, 09/05/2023 and 09/20/2023. The record included a "Medication List" received from Resident 1's physician dated 09/21/2023.

On 09/28/2023 at 2:30 PM, Resident 1's medications in the home included:
- Albuterol (medication to treat/prevent breathing difficulty) inhaler take 2 puffs twice daily if needed (pharmacy label dated 09/25/2023)
-Hydroxyzine (medication used to treat itching caused by allergies) 25 milligrams (mg) take three times daily (pharmacy label dated 9/15/2023)
-Prednisolone acetate (medication to relieve redness, itching in eyes) 1% instill one drop each eye twice a day (pharmacy label dated 08/19/2023)
-Simvastatin (medication to treat cholesterol levels) 40mg take each night (pharmacy label dated 06/26/2023)
-Tamsulosin (medication to treat enlarged prostrate) 0.4mg take daily (pharmacy labels dated 09/01/2023 and 09/25/2023)
-Warfarin 1 mg "per clinic order"

On 09/28/2023 at 2:30 PM, the AFH did not have a medication log for Resident 1 listing each prescribed medication, dosage, how often to give, and at what times. Staff were not recording when or if they were giving medications to the resident for [redacted] days.

On 09/28/2023 at 4:00 PM, Staff A, Provider, stated Collateral Contact (CC1) brought the medications for Resident 1 when they moved into the AFH. Staff A stated they had not created a medication log for Resident 1. Staff A stated they gave the medications to Resident 1 following the pharmacy label direction and the dosage pages from the Anticoagulation Clinic. Staff A stated when they received the physician list of medication on 09/21/2023 they followed those directions.

Resident 2.
Admitted into the home on [redacted]2023. The AFH did not have an assessment for Resident 2. The record included a 'Negotiated Service Plan' showing a move-in date of [redacted]/2023. It was marked to show Resident 2 needed assistance with medications. "Log all medications given and consumed by resident." The residents record included a hospital stay discharge summary dated [redacted]2023, a medication list from the prescriber the Hospice agency dated 09/04/2023.

On 09/28/2023 at 2:45 PM, Resident 2's medications in the home included:
-MiraLAX (laxative) give twice a day for constipation if needed (pharmacy label dated 09/04/2023)
-Senna (medication to treat constipation) 8.6 mg give 1 every 12 hours for constipation (pharmacy label dated 09/04/2023)
-Hydrocodone/APAP (medication is a controlled substance for moderate to severe pain) 7.5/325mg, take 1 every 4 hours if needed for pain (pharmacy label dated 09/07/2023). 20 of 60 tablets in package removed – card dated when tablet removed.
-Lorazepam (medication to relieve anxiety) 0.5-1 mg every 6 hours if needed for agitation/anxiety (pharmacy label dated 09/13/2023). No tablets removed from package.
-Codeine/Guaifenesin (medication to relieve chest congestion/cough) give 5 milliliters (ml) every 4 hours as needed for cough
-Latanoprost (medication to treat glaucoma – progressive eye disease) 0.005% drops, place 1 drop in each eye every 12 hours (pharmacy label dated 06/12/2023)
-Dorzol/Timolol (medication to treat eye conditions including glaucoma) 22.3/6.8 mg,

place 1 drop in each eye at bedtime (pharmacy label dated 06/12/2023)
-Tylenol (medication minor pain reliever) 500 mg – over the counter supply. Hospice direction -give 1 tablet every 6 hours as needed for pain.
-Hyoscyamine (medication reduces saliva produced) 0.125 mg, give every 4 hours if needed for secretions (pharmacy label dated 08/30/2023)
-Morphine Sulfate (medication is a controlled substance for moderate to severe pain) IR 15mg give one-half tab every 4 hours if needed for pain (pharmacy label dated 089/30/2023)
-Haloperidol (medication to treat delirium) 1 mg give every 6 hours if need for agitation (pharmacy label dated 08/30/2023)

On 09/28/2023 at 2:45 PM, the AFH did not have a medication log for Resident 2 listing each prescribed medication, dosage, how often to give, and at what times. Staff were not recording when or if they were giving medications to the resident for [redacted] days.

On 09/28/2023 at 4:00 PM, Staff A, Provider, stated Collateral Contact (CC1) brought medications for Resident 2 to the home when they moved into the AFH. The Hospice pharmacy delivered medications to the home after [redacted]/2023. Staff A stated they had not created a medication log for Resident 2. Staff A stated they gave the medications to Resident 2 following the pharmacy label direction and hospice medication list.

Resident 3.
Admitted into the home on [redacted]/2023. The assessment and preliminary service plan dated 09/22/2023 showed the resident needed assistance with medications. The record included a list of prescribed medications ordered by the Hospice agency on 09/22/2023 effective at the AFH on [redacted]/2023. The AFH had created a medication log for September 2023. On 09/28/2023, Resident 3's medication supply, the September 2023 medication log and orders were reconciled.

On 09/28/2023 at 2:00 PM, the log listed:
-Bactrim DS (medication for infection) give twice a day.
- Seroquel (medication to regulate mood, behavior, and thoughts) 25 mg, give 1-4 tablets (25-100mg) as needed for agitation/restlessness. AFH staff initialed the day when 1, 2 or 3 tablets were given, but did not include the time the dose was given. The log did not show how often the medication could be given. Hospice orders received on [redacted]/2023 showed this direction was discontinued on 09/22/2023. The order on [redacted]/2023 was Seroquel 25 mg give 2 tablets every 4 hours as needed for agitation/restlessness and anxiety and Seroquel 25 mg give 4 tablets daily for anxiety and sleep.
- Lorazepam (medication to help with restlessness and anxiety) 0.5 mg give 2 tabs every 4 hours as needed. Orders [redacted]/2023 show the lorazepam would be used for restlessness not resolved by the Seroquel.
-Melatonin (medication helps with sleep pattern) 10mg give each night
- Morphine 15 mg give one-half to 1 tab. The log did not show how often the dose could be given.
-Ibuprofen (medication for pain relief for mild to moderate pain) 200mg give 2 tablets as needed for pain. The log did not show how often the Ibuprofen could be given. Orders [redacted]/2023 showed the ibuprofen could be given every 4 hours as needed for pain.
-Zofran (medication for nausea) 4mg as needed for nausea. The log did not show how

often the medication could be given. Orders [redacted]/2023 show the Zofran was ordered every 8 hours as needed for nausea/vomiting.

Resident 3 had a package of "Comfort Kit" prescriptions filled by the pharmacy that included directions for how much and when to give. The medications were not listed on the medication log:
- Haloperidol 1 mg vie 1 tablet every 6 hours as needed for agitation.
-Hyoscyamine 0.125 mg dissolve I tab under the tongue every 4 hours as needed for secretions.
-Lorazepam 0.5 mg give one tablet every 6 hours as needed for anxiety or agitation
-Morphine Sulfate IR 15 mg give ½ tab (7.5mg) by mouth or under the tongue every 3 hours as needed for pain or difficulty breathing.
Staff A stated they would add the medications to the log when directed by Hospice to administer the medication.

Resident 3 had additional medications supplied by the pharmacy delivered to the home on 09/26/2023 that were not listed on the September 2023 medication log:
-Quetiapine 100mg give one each night.
- Morphine Sulfate 15mg give 1 tab every 3 hours as needed for pain
-Senna 8.6mg give twice a day for bowel care
Staff A did not contact the prescriber, Hospice, to verify the new directions and/or discontinue previous directions.

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, Eternal Life Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 12/08/2023

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

Liliana Martinez — Provider (or Representative)

12/01/2023 — Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Eternal Life Adult Family Home LLC
Eternal Life Adult Family Home
3713 W Sylvester St
Pasco, WA 99301

RE: Eternal Life Adult Family Home # 755911

Dear Provider:

The Department completed a complaint investigation of your Adult Family Home on 11/13/2023 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 any 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 Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Michelle Closner, Field Manager
Residential Care Services

Region 1, Unit C
1200 Alder Street
Union Gap, WA 98903

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

(1) In locked storage;

On 09/28/2023 at 2:30 PM, closed bags of medications for Resident 2 and Resident 3 were stored on an open shelf in the adult family home refrigerator; not in locked storage.

WAC 388-76-10650 Medical devices.

(2) Before a medical device with a known safety risk is used by a resident, the home must:

(a) Ensure an assessment has been completed that identifies the resident's need and ability to safely use the medical device;

(c) Ensure the resident's negotiated care plan includes how the resident will use the medical device; and

On 09/28/2023, Resident 2 had a side [redacted] on their bed; they were not assessed able to need or could safely use the medical device. The use medical device was not included on their negotiated care plan.

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 (509)572-7394.

Sincerely,
Michelle Closner

Michelle Closner, Field Manager
Region 1, Unit C
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:
Michelle Closner, Field Manager
Residential Care Services
Region 1, Unit C
1200 Alder Street
Union Gap, WA 98903

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