STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Spokane Living Water Adult Family Home LLC

Spokane Living Water Adult Family Home LLC
3104 N Rio Grande Rd
Otis Orchards, WA 99027

RE: Spokane Living Water Adult Family Home LLC License # 756599

Dear Provider:

This letter addresses Compliance Determination(s) 58824 (Completion Date 04/30/2025) and 55271 (Completion Date 03/06/2025).

The Department completed a follow-up inspection of your Adult Family Home on 04/30/2025 and found that you have corrected the violations listed in the Complaint report dated 03/06/2025. Your home is back in compliance as of 04/19/2025 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10400-2, WAC 388-76-10400-3-a, WAC 388-76-10400-3-b, WAC 388-76-10400-4, WAC 388-76-10430-1, WAC 388-76-10430-2-a, WAC 388-76-10430-2-c

The Department staff who did the on-site verification:
Kortne Dunham, NCI Complaint Investigator

If you have any questions, please contact me at (509)598-0182.

Sincerely,

Selena Clemons, Interim Community Field Manager
Region 1, Unit E
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 02/24/2025 and 03/05/2025 of:

Spokane Living Water Adult Family Home LLC
1728 N Stone St
Spokane, WA 99207

This document references the following complaint number(s): 168454, 168872, 168977, 170223

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:

Kortne Dunham, NCI Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit E
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

Selena Clemons
Residential Care Services

03/12/2025
Date

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

Provider (or Representative) _____ Date _____

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

(2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.

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

(a) Actively supports, maintains or improves each resident's quality of life;

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

(4) Services by the appropriate professionals based upon the resident's assessment and negotiated care plan, including nurse delegation if needed.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure staff were available to provide the assessed level of care and support and failed obtain nurse delegation prior to administering medication and completing delegated tasks for 1 of 3 residents (Resident 1). These failures placed the resident's safety at risk, did not promote their highest level of well-being, and resulted in unqualified caregivers completing nurse delegated tasks for the resident.

Findings included...

Review of the AFH's undated Disclosure of Services showed the home offered skilled nursing services by delegation for medication administration, wound care, catheter care, and ostomy care. The Disclosure of Services showed the home offered mobility assistance and transfers including two-person assistance as needed.

Review of Resident 1's record showed an undated and unsigned document titled "Resident Rights" which stated the home would provide caregivers 24/7 that were qualified to provide nurse delegated care. The document showed the home was owned by a registered nurse who would provide necessary nursing services as needed.

Review of Resident 1's annual assessment dated 11/07/2024 showed the resident required two-person physical assistance for repositioning in bed, transfers between surfaces, and bathing. The assessment showed Resident 1 required nurse delegation for application of medication for skin conditions and ostomy (a surgical procedure creating an opening in the abdominal wall that changes the way waste comes out of the body) care.

<Assistance With Mobility>

Observation on 02/24/2025 at 1:25 PM showed Resident 1 and Resident 2, the [redacted] of Resident 1, were sitting in the living room watching television. Resident 1 was sitting in their recliner. Staff A, Caregiver, was the only caregiver in the home. Staff A demonstrated how they used the [redacted] ([redacted]) to transfer Resident 1.

On 02/24/2025 at 1:29 PM, Staff B, Provider, stated Residents 1 and 2 had admitted to the home on [redacted]/2025. Staff B stated they had read the assessment prior to admission and had been aware that Resident 1 required two-person physical assistance with transfers, bed mobility, and bathing. Staff B stated they staffed the AFH with one caregiver at all times, and a second caregiver would come in to help transfer Resident 1 morning and evening. Staff B stated they lived close by and could come in to help with transfers if needed.

On 02/24/2025 at 1:48 PM, Staff A, stated they used the [redacted] to transfer Resident 1 from bed to wheelchair and wheelchair to recliner. Staff A stated they were the only caregiver and used the [redacted] to move Resident 1 because there was not a second caregiver available.

On 02/24/2025 at 2:00 PM, Resident 1 and Resident 2 stated Staff A used the [redacted] to transfer Resident 1. Resident 2 stated Staff A completed the transfers alone. Resident 2 stated that Staff B had been in the home once, since their admission on [redacted]/2025, to provide a two-person assist to Resident 1.

On 03/03/2025 at 12:56 PM, Collateral Contact 1 (CC1), Social Worker, stated they had spoken with Staff B the day after Residents 1 and 2 had been admitted to the home. CC1 stated that Staff B explained they would be unable to meet Resident 1's care needs as they could not staff the AFH with two caregivers. CC1 stated that Staff B denied

having read Resident 1's assessment prior to admission to the AFH

Review of a Physical Therapy progress note dated [redacted]/2025 showed Resident 1 was assessed the day after admission to the home. The progress note showed that when the caregiver was asked how Resident 1 was transferred out of bed in the morning, the caregiver stated that Resident 2 had assisted the caregiver to transfer Resident 1 out of bed. The note showed that the caregiver reported they were the only caregiver in the home. The note showed Resident 1 needed maximum assistance for bed mobility, was unable to sit unsupported on the edge of their bed, and required two-person assist to sit long enough to apply the [redacted] needed to use the [redacted]. The note explained that Resident 1 was able to use the [redacted] to move to other surfaces for sitting and required two-person assistance to position in recliner.

Review of a Physical Therapy progress note dated 02/24/2025 showed Resident 1 was able to use the [redacted] to move from a seated position. The progress noted stated the [redacted] was not effective for use when sitting on edge of bed. The note showed two-persons struggled to provide perineal care (cleaning the private areas to prevent infection) and dressing while using the [redacted] for Resident 1 at the bedside. The progress note recommended two-person assistance for Resident 1 when providing perineal care, dressing, and repositioning in the bed. It was noted that the caregiver was alone during the day.

On 03/03/2025 at 3:18 PM, Collateral Contact 2 (CC2), Registered Nurse, stated Resident 1 was at high risk for pressure injuries (an injury to the skin caused by pressure for long periods of time) and skin breakdown. CC2 stated Resident 1 was not being repositioned or receiving perineal care every two hours as recommended because there was only one caregiver available most of the day. CC2 stated and the caregiver was unable to reposition and change the Resident 1's brief without the assistance of another caregiver.

On 03/03/2025 at 4:18 PM, Staff A explained that another caregiver came into the home to provide assistance around 7:30 AM to help get Resident 1 out of bed, at 2:00 PM a caregiver would return to help get Resident 1 back into their bed, and at 6:30 PM a caregiver returned to help Staff A reposition and change Resident 1.

On 03/03/2025 at 4:25 PM, Staff B stated that another caregiver came to the AFH three times a day to help with care to Resident 1.

On 03/04/2025 at 2:51 PM, Collateral Contact 3 (CC3), Physical Therapist, stated Resident 1's ability to use the [redacted] safely had declined since admission. CC3 reported they had recommended the caregiver use a [redacted] for transfers. CC3 stated two caregivers are necessary to provide perineal care and repositioning to Resident 1 while in bed.

Observation on 03/05/2025 at 8:00 AM showed Resident 2 sitting on the couch watching television. Staff A was the only caregiver in the home.

Observation and interview on 03/05/2025 at 8:25 AM showed Resident 1 was lying in their bed. Resident 1 voiced frustration that they had to stay in bed until a second caregiver arrived to help them change and transfer to their wheelchair.

<Nurse Delegation>

Review of email correspondence between Resident 1's Nurse Delegator and a case management team member dated [redacted]/2025 showed the nurse delegator had been unable to delegate medication administration to Staff A because Staff A did not have an active credential. The email showed that Staff B had agreed to handle medication administration responsibilities in the meantime.

On 03/03/2025 at 3:18 PM, Collateral Contact 2 (CC2), Registered Nurse, stated that Staff A, Caregiver, had been changing the ostomy appliance (a pouch that collects stool that is attached to the skin around the stoma) for Resident 1. CC2 stated Staff A had no experience caring for an ostomy and required education. CC2 stated Resident 1 needed the caregiver to apply their Ketoconazole cream (a topical ointment used to treat fungal infection), Lidocaine patch (a pain-relieving medication), and provide ostomy care.

On 03/03/2025 at 4:18 PM, Staff A stated they had emptied Resident 1's ostomy and changed the appliance every three days Staff A stated they applied cream under Resident 1's breasts and to their buttocks.

On 03/03/2025 at 4:25 PM, Staff B stated they believed Staff A had been delegated to change Resident 1's ostomy. Staff B stated they did not think that any of Resident 1's medications required nurse delegation.

A search completed on 03/04/2025 of the Washington State Department of Health Provider Credential Search website showed Staff A's nursing assistant registered (NAR) credential was pending.

On 03/04/2025 at 3:11 PM, Collateral Contact 4 (CC4), Registered Nurse Delegator stated they had been unable to delegate tasks and medication administration to Staff A because Staff A did not have an active credential. CC4 stated they had notified Staff B that Staff B would need to administer medication and change the ostomy appliance for Resident 1.

On 03/05/2025 at 8:25 AM, Resident 1 and 2 reported Staff A changed Resident 1's ostomy appliance and applied cream.

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, Spokane Living Water 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 388-76-10430 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:

(a) Assessment indicates the amount of medication assistance needed by the resident;

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

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure medications were given as ordered and failed to ensure the medication log accurately reflected the medications given to 1 of 3 residents (Resident 1). These failures resulted in Resident 1 experiencing a delay of a necessary medical procedure.

Findings included…

On 03/05/2025 at 1:12 PM, Collateral Contact 2 (CC2), Registered Nurse, stated they had just finished a visit to the AFH and had concerns regarding medication administration. CC2 stated Resident 1 was scheduled for an endoscopic retrograde cholangiopancreatography (ERCP) (a procedure to show imaging of internal organs) the following day, 03/06/2025. CC2 stated the AFH had been sent a physician's order to hold Resident 1's aspirin (a blood thinning medication) tablet for a week prior to the scheduled procedure. CC2 stated the medication administration record (MAR) showed the aspirin tablet had been given by Staff B, Provider, each morning through 03/03/2025. CC2 explained that they had asked Staff A, Caregiver, why the aspirin tablet had been given, and Staff A had stated they had not administered the aspirin tablet and that the aspirin was being held as ordered. CC2 stated they contacted Staff B

requesting clarification on whether the aspirin had been given. According to CC2, Staff B said the aspiring had not been given even though they had documented in the MAR that the aspirin had been given to Resident 1.

In an email received on 03/05/2025 at 4:14 PM, CC2 explained that since they were unable to verify if Resident 1's aspirin had been held, Resident 1's medical team decided to cancel the resident's surgery.

Review of a physician order that had been faxed to the AFH on 02/24/2025 instructed to the AFH to hold Resident 1's Aspirin 81mg chewable tablet from 02/27/2025-03/06/2025.

On 03/05/2025 at 8:25 AM, Resident 1 complained of pain in their left knee. Resident 1 stated they had not been receiving their Lidocaine patch since their admission.

Review of the MAR on 03/05/2025 had shown Staff B had initialed, indicating administration of the Lidocaine patch each day since Resident 1's admission to the AFH on [redacted]/2025.

On 03/05/2025 at 1:06 PM, Collateral Contact 5 (CC5), Pharmacy Technician, stated the pharmacy had sent a 30-day supply of the lidocaine pain patch on 02/03/2025 and an 11-day supply on 03/03/2025.

On 03/06/2025 at 8:16 AM, Staff B stated the aspirin tablet had been held as ordered and that the documentation in the MAR was in error. Staff B stated they had run out of Lidocaine patches for Resident 1. Staff B stated Resident 1 had not been receiving the lidocaine patches.

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, Spokane Living Water 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