



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

Statement of Deficiencies	License #: 361302	Completion Date
Plan of Correction	SUNNY HILL HOME CARE B	January 26, 2016
Page 1 of 11	Licensee: Daniel Hapaianu	

You are required to be in compliance with all of the licensing laws and regulations at all times to maintain your adult family home license.

The department has completed data collection for the unannounced on-site full inspection of:  
 1/14/2016

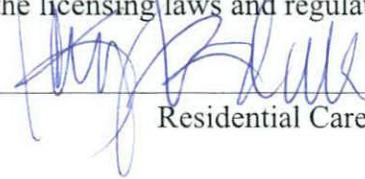
SUNNY HILL HOME CARE B  
 13927 14TH PL W  
 LYNNWOOD, WA 98087

The department staff that inspected the adult family home:  
 Hang Lu, BSN, Licensor

From:  
 DSHS, Aging and Long-Term Support Administration  
 Residential Care Services, Region 2, Unit B  
 3906-172nd St NE, Suite #100  
 Arlington, WA 98223  
 (360)651-6872

RECEIVED  
 FEB 22 2016  
 ADSA/RC  
 Smiley, P.

As a result of the on-site full inspection 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

1/31/16  
 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.

X   
 Provider (or Representative)

X 2/17/16  
 Date

**WAC 388-76-10198 Adult family home Personnel records. The adult family home must keep documents related to staff in a place readily accessible to authorized department staff. These documents must be available during the staff's employment, and for at least two years following employment. The documents must include but are not limited to:**

- (2) Staff orientation and training records pertinent to duties, including, but not limited to:
- (a) Training required by chapter 388-112 WAC, including as appropriate for each staff person, orientation, basic training or modified basic training, specialty training, nurse delegation core training, and continuing education;

**WAC 388-112-0035 What documentation is required for facility orientation training? The adult family home or assisted living facility must maintain documentation that facility orientation training has been completed as required by this chapter. The training and documentation must be issued by the home or service provider familiar with the facility, and must include:**

- (1) The name of the student;
- (2) The title of the training;
- (3) The number of hours of the training;
- (4) The signature of the instructor providing facility orientation training;
- (5) The student's date of hire;
- (6) The date(s) of facility orientation;
- (7) The documentation required under this section must be kept in a manner consistent with WAC 388-76-10198 (for adult family homes) and WAC 388-78A-2450 (for assisted living facilities).

**This requirement was not met as evidenced by:**

Based on record review and interview, the provider failed to have a system in place to ensure the orientation for 4 of 4 caregivers (Caregiver A, B, C, D) was documented, as required.

Findings include:

All record review and interview occurred on 1/14/16 unless otherwise noted.

Interview and record review revealed the following:

-----Caregiver A (the provider's spouse) was hired to work when the home opened on 6/20/03. Caregiver A lived in the home and she was on duty during the inspection.

-----Caregiver B was hired to work in the home on 9/15/15. Caregiver B worked 7 AM to 7 PM five days a week and she was on duty during the inspection.

-----Caregiver C was hired to work in the home on 5/20/15. Caregiver C lived on the premises and she worked when needed (on-call).

-----Caregiver D was hired to work in the home on 5/22/15. Caregiver D worked on Sundays (7 AM to 7 PM).

-----There was a continuing education (CE) certificate for overall orientation to adult family

homes in each Caregiver's file; however, this orientation was not specific to the adult family home. There was no evidence in any of the caregivers' records to indicate the provider gave them orientation training when they started working in the home.

When asked, Caregiver A said she did not know about the requirement. Caregiver A said she would tell the provider to fax the orientation forms to the licenser soon.

On 1/15/16, the licenser received a fax from Caregiver A. Review of the faxed documents revealed the provider had completed the orientation form for Caregiver A, Caregiver B, and Caregiver D on 1/14/16; however, the date of hire and hours of training were not documented.

#### 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, SUNNY HILL HOME CARE B is or will be in compliance with this law and / or regulation on (Date) X 2/17/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

X Daniel Hapaianu  
Provider (or Representative)

X 2/17/16  
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:**

- (5) The resident's activities preferences and how the preferences will be met;
- (6) Other preferences and choices about issues important to the resident, including, but not limited to:
  - (a) Food;
  - (b) Daily routine;
  - (c) Grooming; and
  - (d) How the home will accommodate the preferences and choices.
- (7) If needed, a plan to:
  - (b) Reduce tension, agitation and problem behaviors;

**This requirement was not met as evidenced by:**

Based on record review and interview, the provider failed to have a system in place to ensure the negotiated care plans (NCPs) for 2 of 2 sampled residents (Resident 2, 3) included the residents' preferences/ choices and how the home accommodated the residents. In addition, the provider failed to address Resident 2's behavior as identified in the assessment. This failure placed the residents at risk of unmet or unrecognized care needs.

Findings include:

All record review and interview occurred on 1/14/16 unless otherwise noted.

Resident 2 was admitted to the home on [redacted] 11. Review of her assessment dated 3/16/15 revealed she had [redacted] Record review revealed there was no information about the resident's [redacted] and how the home intervened in the behavior section of the resident's negotiated care plan (NCP). In addition, there was only one preference noted in the NCP, indicating the resident preferred to stay in bed all day. There were no other preferences noted regarding other aspects of the resident's life.

Resident 3 was admitted to the home on [redacted] 14. Review of his NCP revealed there was no information at all regarding the resident's preferences and choices.

When interviewed, Caregiver A said she would update the NCPs soon to include all required information.

On 1/15/16, the licenser received a fax from Caregiver A. Review of the faxed documents revealed Caregiver A had updated the NCPs to include the preferences (for Resident 2 and Resident 3) and behavior (for Resident 2).

**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, SUNNY HILL HOME CARE B is or will be in compliance with this law and / or regulation on (Date) 2/17/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

[Signature]  
Provider (or Representative)

2/17/16  
Date

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

- (1) Resident; and
- (2) Adult family home.

**This requirement was not met as evidenced by:**

Based on record review and interview, the provider failed to have a system in place to ensure the negotiated care plans (NCPs) for 2 of 2 sampled residents (Resident 2, 3) were agreed to, signed, and dated by the residents or their representatives and provider, as required.

**Findings include:**

All record review and interview occurred on 1/14/16 unless otherwise noted.

Record review revealed Resident 2 was admitted to the home on [redacted] 1 and her negotiated care plan (NCP) was last agreed to, signed, and dated by her power-of-attorney (POA) and the provider on 6/8/11. The provider documented review dates on the signature page of the NCP in subsequent years; however, there was no evidence the NCP was agreed to and signed by the

POA and provider every year after each update.

Record review revealed Resident 3 was admitted to the home on [REDACTED] 4 and his NCP was last agreed to and signed by the resident's representative and provider on 12/9/14. The provider updated the NCP on 12/9/15; however, there was no evidence the updated NCP was agreed to, signed, and dated by the resident's representative and provider.

When interviewed, Caregiver A (the provider's spouse) said she would make sure to review the NCPs with the residents/ representatives, and obtain their signatures soon.

#### Attestation Statement

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X   
Provider (or Representative)

X 2/17/16  
Date

#### WAC 388-76-10430 Medication system.

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

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

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

(d) Receives medications as required.

#### WAC 388-76-10470 Medication Timing Special directions.

(1) The adult family home must ensure medications are given:

(b) As follows, when the practitioner does not order a medication to be given at a specific time:

(ii) Two times a day, approximately twelve hours apart;

(iii) Three times a day, approximately six hours apart; and

#### WAC 388-76-10475 Medication Log. The adult family home must:

(2) Include in each medication log the:

(c) Dosage of the medication;

#### This requirement was not met as evidenced by:

Based on observation, record review and interview, the provider failed to have a system in place to ensure services provided for 1 of 2 sampled residents (Resident 2) met all laws and rules relating to medications, the resident received medications as ordered, and the medication log

was accurate and up-to-date. This failure placed the resident at risk of medication errors.

Findings include:

All observation, record review, and interview occurred on 1/14/16 unless otherwise noted.

Record review revealed Resident 2 was admitted to the home with medically disabling diagnoses including [REDACTED]. The resident was on multiple medications. Observation of the resident's medication supply and review of the physician's orders (dated 12/7/15) and medication log revealed:

-----Calcium: The entry on the medication log read, "Calcium 600 mg 2x day" and the time given were 7:30 AM and 5 PM. The doctor's order read, "Calcium 600 mg by mouth twice daily." The label on the over-the-counter (OTC) bottle indicated "Calcium + (Vitamin) D3 (600 mg/ 400 IU) tablets. When asked, Caregiver A did not realize the medication in the OTC bottle included Vitamin D3.

-----Vitamin C: The entry on the medication log read, "Vitamin C 500 mg 1x day". The label on the OTC bottle indicated each tablet was 1000 mg. When asked, Caregiver A did not realize the dosage discrepancy.

-----Fish Oil: The entry on the medication log read, "Fish Oil 1000 mg 2x day" and the times given were 7:30 AM and 5 PM. There was an OTC Fish Oil bottle in the resident's medication supply, and the provider/ Caregiver A had been initialing on the medication log (indicating they had been giving this medication); however, this medication was not on the doctor's medication list for the resident. When asked, Caregiver A could not find any document to indicate the doctor had given an order or he/ she was aware the resident was taking Fish Oil.

---- [REDACTED] eye drops: The entry on the medication log read, [REDACTED] (mispelling) 5% drops 1x day". The doctor's order read, [REDACTED] 0.5% eye drops, Instill 1 drop into both eyes daily at bedtime." When asked, Caregiver A acknowledged the medication entry on the medication log needed to be transcribed accurately and as written by the doctor.

----- [REDACTED] eye drops: The entry on the medication log read, [REDACTED] 1x day" and the time given was 5 PM. The doctor's order read, [REDACTED] 0.005 % eye drops, Instill 1 drop into both eyes daily at bedtime."

---- [REDACTED] suppository: The entry on the medication log read, [REDACTED] Suppository PRN (as needed)". The doctor's order read, [REDACTED] 10 mg suppository, Insert 1 suppository into rectum everyday PRN."

----- [REDACTED] eye drops: The entry on the medication log read, [REDACTED] 2x day" and the times given were 7:30 AM and 5 PM. The doctor's order read, [REDACTED] eye drops, Instill 1 drop into both eyes 2 times daily."

----- [REDACTED] eye drops: The entry on the medication log read, [REDACTED] 3 x day" and the times given were 7:30 AM, 12 PM, and 5 PM. The doctor's order read, [REDACTED] eye drops, Instill 1 drop in both eyes three times a day."

██████████ The entry on the medication log read, "██████████ mg 1 x day" and the time given was 8 PM. The doctor's order read, "██████████ mg tablet, Take one-half tablet (██████████ mg) everyday at bedtime."

██████████ The entry on the medication log read, "██████████ mg 1x day" and the time given was 8 PM. The doctor's order read, "██████████ mg tablet, Take 0.5 tablet (25 mg) by mouth at bedtime."

-----Tylenol: The entry on the medication log read, "Tylenol 650 mg" and the time given was "PRN". The doctor's order read, "Acetaminophen (Tylenol) 325 mg tablet, Take 2 tablets (650 mg) by mouth every 4 hours as needed for pain or fever."

██████████ The entry on the medication log read, "██████████" and the time given was "PRN". The doctor's order read, "██████████ mg tablet, Take one tablet every day PRN constipation."

During an interview, Caregiver A said she would transcribe medication orders onto the medication log completely and accurately (as written by the doctor) from now on. Caregiver A said she would adjust the timing of medication administration, so that medications ordered twice daily would be given approximately 12 hours apart, and medications ordered three times daily would be given approximately 6 hours apart. Caregiver A said she would contact the doctor regarding the Fish Oil.

On 1/15/16, the licenser received a fax from Caregiver A. Review of the faxed document revealed Caregiver A had updated Resident 2's medication log (by transcribing medication orders completely and adjusting the timing of medication administration per regulation); however, the PRN Acetaminophen and ██████████ orders were missing (i.e. not listed on the medication log).

#### Attestation Statement

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██████████  
Provider (or Representative)

2/17/16  
Date

**WAC 388-76-10522 Resident rights Notice Policy on accepting medicaid as a payment source. The adult family home must fully disclose the home's policy on accepting medicaid payments. The policy must:**

- (3) Be provided to prospective residents, before they are admitted to the home;
- (4) Be provided to any current residents who were admitted before this requirement took effect

or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

**This requirement was not met as evidenced by:**

Based on record review and interview, the provider failed to have a system in place to ensure 2 of 5 residents (Resident 1, 3) had signed and dated the home's written policy on accepting Medicaid as a payment source. This failure placed the residents at risk of not being fully aware of their rights.

Findings include:

All record review and interview occurred on 1/14/16 unless otherwise indicated.

During record review, the records for Resident 1 and Resident 3 did not have the signed and dated policy on how the home accepted Medicaid funds as a payment source. Resident 1 was on Medicaid and was admitted to the home on [REDACTED] 5, and Resident 3 was also on Medicaid and was admitted to the home on [REDACTED] 4. When interviewed, the provider's spouse (Caregiver A) said she had thought only the private pay residents needed to sign the policy.

During the inspection, Caregiver A proceeded to provide Resident 3 with a copy of the home's Medicaid policy and obtain his signature.

This is a REPEAT deficiency from the full inspection on 5/30/13.

**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, SUNNY HILL HOME CARE B is or will be in compliance with this law and / or regulation on (Date) X 2/17/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

X [Signature]  
Provider (or Representative)

X 2/17/16  
Date

**WAC 388-76-10530 Resident rights Notice of services. The adult family home must provide each resident notice in writing and in a language the resident understands before admission, and at least once every twenty-four months after admission of the:**

- (1) Services, items, and activities customarily available in the home or arranged for by the home as permitted by the license;
- (2) Charges for those services, items, and activities including charges for services, items, and activities not covered by the home's per diem rate or applicable public benefit programs; and
- (3) Rules of the home's operations.

**This requirement was not met as evidenced by:**

Based on record review and interview, the provider failed to have a system in place to ensure 3 of 5 sampled residents (Resident 1, 3, 4) received a notice of services (admission agreement) at admission. In addition, the provider failed to ensure 2 of 5 residents (Resident 2, 4) received the admission agreement at least every 24 months after admission. This failure placed the residents at risk of not knowing the rules or understanding care and services provided by the home.

**Findings include:**

All record review and interview occurred on 1/14/16 unless otherwise noted.

**Record review revealed the following:**

---Resident 1 was admitted to the home on [REDACTED] 5. There was no evidence the resident or her representative had received, and signed/ dated admission agreement at the time of her admission in her records.

---Resident 3 was admitted to the home on [REDACTED] 4. There was no evidence the resident had received, and signed/ dated admission agreement at the time of his admission in her records.

---Resident 4 was admitted to the home on [REDACTED] 3. There was no evidence the resident or his power of attorney (POA) had received, and signed/ dated admission agreement at the time of his admission and at least 24 months after admission in his records.

---Resident 2 was admitted to the home on [REDACTED] 1. There was no evidence the resident or her representative had received, and signed/ dated admission agreement at least 24 months after admission in her records.

When interviewed, Caregiver A said she did not know it was a requirement for Medicaid residents to have admission agreements. Caregiver A then proceeded to provide Resident 3 with a copy of the admission agreement and obtain his signature.

**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, SUNNY HILL HOME CARE B is or will be in compliance with this law and / or regulation on (Date) 2/17/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

  
Provider (or Representative)

 2/17/16  
Date

**WAC 388-76-10585 Resident rights Examination of inspection results.**

(1) The adult family home must place the following documents in a visible location in a common use area where they can be examined by residents, resident representatives, the department and anyone interested without having to ask for them.

(a) A copy of the most recent inspection report and related cover letter; and

(2) The adult family home must post a notice that the following documents are available for review if requested by the residents, resident representatives, the department and anyone interested.

(a) A copy of each inspection report and related cover letter received during the past three years; and

(b) A copy of any complaint investigation reports and related cover letters received during the past three years.

**This requirement was not met as evidenced by:**

Based on observation and interview, the provider failed to have a system in place to ensure the most recent inspection report was available in a visible location where it could be examined by anyone interested without having to ask for it, as required. In addition, a notice that previous inspection and complaint investigation reports were available upon request was not posted, as required.

Findings include:

All observation and interview occurred on 1/14/16 unless otherwise noted.

During a tour of the home, the licenser noted the one-paged follow-up letters from 7/2014 and 7/2013 were posted and there was a notice indicating "provider's information available" on the wall in the common area. When asked, Caregiver A said she kept the full inspection results in her file. During an interview, Caregiver A said she would make sure to post the latest full inspection report on the wall and revise the notice to say, "Inspection and complaint investigation reports from the last three years are available upon request."

This is a REPEAT deficiency from the full inspection on 5/30/13.

**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, SUNNY HILL HOME CARE B is or will be in compliance with this law and / or regulation on (Date) X 2/17/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

X [Signature]  
Provider (or Representative)

X 2/17/16  
Date

**WAC 388-112-0205 Who is required to complete continuing education training, and how many hours of continuing education are required each year?**

(1) Adult family homes

(a) From January 1, 2012 through June 30, 2012, adult family home providers, entity representatives, resident managers, and long-term care workers whose birth date is within these dates and the required basic training was previously completed must complete ten hours of continuing education. If ten hours of continuing education were completed between January 1, 2012 through June 30, 2012 for any one listed above, regardless of birth date, then the continuing education requirements have been met for 2012.

(c) If exempt from certification as described in RCW 18.88B.041 , all long-term care workers must complete twelve hours of continuing education per year.

**This requirement was not met as evidenced by:**

Based on record review and interview, the provider failed to have a system in place to ensure 1 of 4 caregivers (Caregiver A) completed the required 12 hours of continuing education (CE) credits between her birthdays in 2014 and 2015. This failure left the residents with a caregiver who was not fully qualified.

Findings include:

All record review and interview occurred on 1/14/16 unless otherwise noted.

During staff record review, the licensor noted the provider's spouse (Caregiver A) only had the required (1/2 hour) food safety training on 4/30/15. When asked, Caregiver A could not locate any other CE credits obtained between her birthdays (4/22/14 and 4/22/15). When interviewed, Caregiver A said she was sure she had completed all 12 CE hours last year. Caregiver A said she would look for the CE documents and fax to the licensor by the next day.

On 1/15/16, the licensor did not receive any of Caregiver A's CE certificates via fax.

This is a REPEAT deficiency from the full inspection on 5/30/13 (previously cited under WAC 388-12-0245).

**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, SUNNY HILL HOME CARE B is or will be in compliance with this law and / or regulation on (Date) 2/17/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

  
 Provider (or Representative)

2/17/16  
 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

March 29, 2016

Daniel Hapaianu  
SUNNY HILL HOME CARE B  
13927 14TH PL W  
LYNNWOOD, WA 98087

RE: SUNNY HILL HOME CARE B License #361302

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on March 21, 2016 for the deficiency or deficiencies cited in the report/s dated January 26, 2016 and found no deficiencies.

The Department staff who did the inspection:  
Hang Lu, Licensor

If you have any questions please, contact me at (360) 651-6872.

Sincerely,

Kay-Randall, Field Manager  
Region 2, Unit B  
Residential Care Services