



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032-2388

July 19, 2016

AMERICAN ASSOCIATION ADULT FAMILY HOME CARE LLC
AMERICAN ASSOCIATION ADULT HOME CARE
14514 STONE AVE N
SHORELINE, WA 98133

RE: AMERICAN ASSOCIATION ADULT HOME CARE License #549400

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on July 15, 2016 for the deficiency or deficiencies cited in the report/s dated April 21, 2016 and found no deficiencies.

The Department staff who did the inspection:
Brenda Mooney, Licensors

If you have any questions please, contact me at (253) 234-6033.

Sincerely,

Bennetta Shoop, Field Manager
Region 2, Unit E
Residential Care Services



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032-2388

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Statement of Deficiencies	License #: 549400	Completion Date
Plan of Correction	AMERICAN ASSOCIATION ADULT HOME CARE	April 21, 2016
Page 1 of 8	Licensee: AMERICAN	

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:
4/20/2016

AMERICAN ASSOCIATION ADULT HOME CARE
14514 STONE AVENUE
SHORELINE, WA 98133

The department staff that inspected the adult family home:
Brenda Mooney, M.A., Licensor

From:

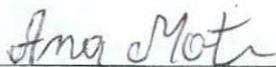
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit E
20425 72nd Avenue S, Suite 400
Kent, WA 98032-2388
(253)234-6033

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

04/29/2016
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)

05.12.16
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

This requirement was not met as evidenced by:

Based on interview and record review, the home did not ensure that the negotiated care plan for 1 of 2 sample residents (Resident #1) had been signed. Failure to ensure that the care plans are signed is a failure to ensure that care procedures were reviewed and consented to.

Findings include:

On 4/20/16, a review of Resident #1's care plan revealed that it had not been signed by the resident/resident's representative. Resident # 1 had been admitted to the home on [REDACTED] 15, and had a care plan dated [REDACTED] 15.

The Provider said that Resident #1's representative was frequently at the home but no explanation was offered as to why the resident's care plan had not been reviewed and signed as required.

The home was previously cited for this on 1/28/14 and 2/26/2013.

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, AMERICAN ASSOCIATION ADULT HOME CARE is or will be in compliance with this law and / or regulation on (Date) 5/22/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

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Provider (or Representative)

05.12.16
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
 - (c) Reasonably accommodates each resident's individual needs and preferences except when the accommodation endangers the health or safety of the individual or another resident.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the home did not ensure that 1 resident had necessary medication administration supervision (Resident #2), and another resident received

medications as ordered (Resident#1). Failure to ensure that medication administration was supervised for one resident and that medication was given as ordered for another, had the potential to result in harm to each resident's health and well-being.

Findings include:

Observation, interview, and record review occurred on 04/20/2016 unless otherwise noted.

Resident #2:

Resident #2 was admitted to the home on [REDACTED] 15. Review of Resident #2's record revealed that [REDACTED] had multiple diagnoses. Due to a [REDACTED] Resident #2 had undergone surgical procedures in 2015 to initiate [REDACTED]. The resident was currently self-managing at the home with 12 hour [REDACTED]. Resident #2 had dental surgery to remove [REDACTED] teeth in 1/2016 due to poor dentition and had [REDACTED] medications increased at that time. Resident #2 was seen in the emergency room on [REDACTED] 16 for an infection on [REDACTED] for which [REDACTED] was given an [REDACTED].

Resident #2 was allowed soft foods by mouth but the Provider said [REDACTED] frequently refused food items offered. The Provider showed the licenser a piece of paper on which in large letters and with a black marker, Resident #2 had printed a message to the Provider stating [REDACTED] did not want to be offered food. Asked what foods Resident #2 would take, the Provider pointed out a carton of fat free milk in the refrigerator that she said belonged to Resident #2.

A review of Resident #2's assessment dated 11/30/15 revealed that the resident required assistance with medication management. The assessment stated that Resident #2's ability to manage [REDACTED] medications fluctuated, or was not consistent. The instructions given in the assessment stated that the the home was to hand medications to the resident in a cup or bowl, put the medications in a locked container and document medications given as well as report adverse reactions.

Resident #2's care plan dated 11/20/15, restated the assessment instructions as what the caregiver was to do.

A review of medications revealed that several medications belonging to Resident #2 were not available in the home's medicine cabinet. The Provider said that Resident #2 kept [REDACTED] medications in [REDACTED] room in a lockbox. The Provider was asked if she could access the lockbox in order for the licenser to check them against the home's medication log and [REDACTED] answered in the negative, that Resident #2 would not allow others to access [REDACTED] medications for review. Among the medications held by Resident #2 were 3 [REDACTED] medications [REDACTED] and a medication to help [REDACTED].

A review of Resident #2's last medical appointment in 1/2016 stated that Resident #2 was [REDACTED]. A review of the medication log for Resident #2's medications revealed that Resident #2's [REDACTED] 5 mg was to be taken up to 5 times daily as needed (2 tabs). However, the medication log in the home was signed by the Provider only once a day.

In an interview, the Provider said she did not directly supervise Resident #2's medication-taking.

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Further interview revealed that the Provider had no reliable system with which to monitor Resident #2's usage of [REDACTED] medications. The Provider said she signed the log because Resident #2 said [REDACTED] had taken [REDACTED] medications. The Provider did not know if Resident #2 had taken the correct medications in the correct amounts at the correct times.

Similarly, Resident #2 had [REDACTED] (10mg) to be taken three times daily for pain. [REDACTED] had [REDACTED] prescribed as 2 tabs to be taken every 4 hours for signs of [REDACTED] as needed. Resident #2's [REDACTED] 150 mg was to be taken once every night for [REDACTED]

The instructions in Resident #2's assessment and care plan were not being followed in the home.

Resident #2 was observed briefly in [REDACTED] room on the morning of 4/20/16 but [REDACTED] did want to be disturbed before noon as [REDACTED] was sleeping. When asked why Resident #2 was not up and ready for [REDACTED] day, Caregiver A said that Resident #2 was up until 4 a.m. The Provider then said that Resident #2 had updated her that [REDACTED] did not want to be disturbed until 6 p.m. in the evening.

No action had been taken by the home to discuss with Resident #2 what issues were affecting [REDACTED] ability to sleep at night, or to ensure that there was some follow-up with Resident #2's physician. There was no evidence that the home had devised any plan of care. Further the home was not overseeing Resident #2's medication regimen and had not initiated any procedures to ensure that Resident #2 did not ingest increasing or excessive amounts of [REDACTED] medications. The Provider said that Resident #2 was cognitively capable and made choices for [REDACTED] self.

At approximately 1 p.m. an attempt was made by the licenser to access Resident #2 for an interview. However, the Provider said that Resident #2 had left the home with [REDACTED] representative payee and she did not know when [REDACTED] would return.

Resident #1:

Review of Resident #1's record revealed the resident had several diagnoses, among them was a diagnosis of [REDACTED] usually associated with [REDACTED] and [REDACTED]

A review of Resident #1's medications revealed Resident #1 had an order for [REDACTED] to be administered 4 times a day. This medication had to be administered because Resident #1 had significant [REDACTED] and was unable to do this task [REDACTED] self. The Provider signed that this medication had been given on the morning of 4/20/16 but there was no container of [REDACTED] among Resident #1's medications. The Provider then said she had just run out of the medication but was unable to produce the empty bottle.

Resident #1's assessment dated 11/30/15 and care plan dated 1/10/16 stated that the Provider was responsible for re-ordering medications.

Resident #1 had an order for [REDACTED] 5 mg take 2 tablets (10 mg) daily as needed for [REDACTED]. However, a review of Resident #1's medication log revealed that the Provider gave this medication from 4/1 to 4/12 daily and then again from 4/14 to 4/20 daily. Resident #1 also had an order for [REDACTED] 250 mg for [REDACTED] every twelve hours as needed. The medication log showed that this had been given on a daily basis from 4/1 through 4/20.

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Constipation was defined as as going two days without a bowel movement. The home's log of Resident #1's bowel movements showed [redacted] was not constipated except for two times (on 4/6 and 4/11).

The Provider said Resident #1 gets constipated and needs the medication daily.

Resident #1 had an order for [redacted] 0.5 mg (a [redacted] to be given twice a day as needed for [redacted]. A further notation made by the physician said Resident #1 could receive one dose at bedtime if the Resident's prescription for [redacted] did not work to help [redacted] with [redacted]. The medication log in the home showed that Resident #1 received a dose of [redacted] at bedtime in conjunction with the [redacted].

When asked about this, the Provider said she gave the [redacted] to Resident #1 because it helped [redacted]. The Provider had not discussed with Resident #1's representative or physician about the ongoing daily use of this [redacted] nor did she wait any period of time to see if the [redacted] was sufficient for the resident as instructed.

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, AMERICAN ASSOCIATION ADULT HOME CARE is or will be in compliance with this law and / or regulation on (Date) 5/22/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Ana Mot
Provider (or Representative)

05.12.16
Date

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WAC 388-76-10430 Medication system.

- (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.

This requirement was not met as evidenced by:

Based on interview and record review, the home did not ensure that there was a consistent and reliable medication system in place for 4 of 5 residents (Residents #1; #2; #3; #5). Failure to ensure that the medication log was kept current and that medications were given as required had the potential to result in harm to residents.

Findings include:

Observation, interview, and record review occurred on 04/20/2016 unless otherwise noted.

A review of the medication logs in the home revealed several discrepancies.

Resident #1:

Resident #1's medication log had two listings for his [REDACTED] 25mg to be given one nightly as needed for [REDACTED]. One of the listings was handwritten. The Provider signed both the printed and handwritten listing as giving two [REDACTED] every day from 04/01-04/19.

Observation of Resident #1's bubble packed medications showed that they were not given with numbered bubbles corresponding to dates for the month. The bubble packed medications were also not labeled for which date they were started. When asked when the [REDACTED] bubble pack was started the Provider said it was started the day the bubblepack was issued (4/9/16). Only 6 bubbles had been popped indicating that the bubble pack was up-to-date for 4/15 if she gave one pill a day, or 4/12 if she gave 2 pills a day. This further indicated that there were 5 days that Resident #1 had not received [REDACTED] medication if the Provider was accurate about the date the bubblepack was started. The Provider said she only gave the medication once daily but was unable to show any proof of this.

Resident #1 had an order for [REDACTED] to be given as two tabs (10 mg) to be given as needed for [REDACTED]. The medication log showed that the Provider had given the medication 4/1-4/12, and 4/14-4/20. However, no bubble pack with this medication was found in Resident #1's container of medications. The Provider looked through the medications several times and was unable to locate this medication although she had signed the medication log stating Resident #1 had received this medication on this morning (4/20).

Resident #1 had an order for [REDACTED] which were to be given 4 times a day. The Provider signed the medication log only once a day instead of 4 times. The medication log stated that [REDACTED] received this medication on 4/20 but no bottle of this medication was found. The Provider said the medication had just finished but was unable to retrieve any empty bottle in the home.

Resident #2:

Resident #2 had an order for several medications taken for [REDACTED] and [REDACTED] (discussed under WAC 388-76-10400 of this report) which were signed by the Provider as given to the Resident. However, the Provider had neither given these medications to the resident nor had she seen them ingested. Resident #2 was keeping the medications in [REDACTED] room and was self-medicating.

Resident#3:

Resident #3 's medications [REDACTED] and [REDACTED] came to the home in a roll of tear-away daily strips which had the date for administration on them. Although the medication log signed by the Provider stated Resident #3 received [REDACTED] medications daily, the tear-away daily strips for 4/16 through 4/20 were still intact in [REDACTED] medication strip roll. The Provider said she just takes the next strip in the roll every day and gives the medications to Resident #3 and provided no explanation for the additional tear-away packs that were still present.

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Resident#5:

Resident #5 had an order for [redacted] to be given 1/2 -1 tablet twice daily as needed for [redacted]. The medication log showed Resident #5 received this medication daily in February (2/1-2/29/16); most of March 3/1, 3/4-3/5; and 3/7-3/31; and all of April to date. There was no specification on the medication log showing whether Resident #5 had received 1/2 tab or 1 tab of this medication. The Provider said Resident #5 needed it. There was no specification on the medication log showing whether Resident #5 had received 1/2 tab or 1 tab of this medication.

A review of medications for Resident#5 revealed no [redacted] was found in Resident #5's container. The Provider was unable to explain how she had given the medication when it could not be located in the home.

This is a repeated deficiency previously cited on 02/16/2014 and 03/27/2008.

Attestation Statement

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Ana Mot

Provider (or Representative)

05.12.16

Date

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WAC 388-76-10750 Safety and maintenance. The adult family home must:

(6) Provide storage for toxic substances, poisons, and other hazardous materials that is only accessible to residents under direct supervision, unless the resident is assessed for and the negotiated care plan indicates it is safe for the resident to use the materials unsupervised;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the home did not ensure that toxic items were kept inaccessible to residents. Failure to ensure that toxic items were inaccessible had the potential to endanger the health and well-being of vulnerable adults.

Findings include:

On 4/20/16, a tour of the home revealed that a bottle of Windex was freely accessible on a sofa in the common area. This cleaning agent was marked "keep out of reach of children". Additionally, a bottle of Listerine mouthwash was freely available on the sink in a bathroom located between Resident #1 and Resident #3's rooms. Both Resident #1 and Resident #3 were compromised in their cognitive ability.

Record review revealed no information in Resident #1 or #3's assessments indicating they were

safe around toxic materials. Other residents (Resident #4,#5) who were ambulatory were capable of accessing Resident #3' bathroom although this was not their usual practice.

The Provider said she did not think these items were toxic.

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, AMERICAN ASSOCIATION ADULT HOME CARE is or will be in compliance with this law and / or regulation on (Date) 5/22/16 . In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Ana Met

Provider (or Representative)

05.18.16

Date

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