



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

August 8, 2016

PINEHURST SERVICES INC  
PINEHURST HOME  
11534 7TH AVE NE  
SEATTLE, WA 98125

RE: PINEHURST HOME License #732800

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on August 5, 2016 for the deficiency or deficiencies cited in the report/s dated June 6, 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

---

Statement of Deficiencies	License #: 732800	Completion Date
Plan of Correction	PINEHURST HOME	June 6, 2016
Page 1 of 9	Licensee: PINEHURST SERVICES	

---

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:  
6/1/2016

PINEHURST HOME  
13516 23RD PL NE  
SEATTLE, WA 98125

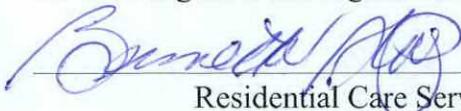
The department staff that inspected the adult family home:  
Brenda Mooney, M.A., Licensors

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

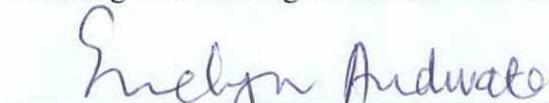
RECEIVED  
AUG 09 2016  
DSHS/ALTS/RCS

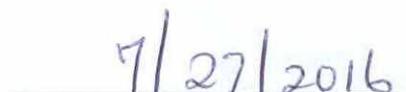
As a result of the on-site full inspection the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

  
Residential Care Services

  
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 388-76-10320 Resident record Content. The adult family home must ensure that each resident record contains, at a minimum, the following information:**

(10) A current inventory of the resident's personal belongings dated and signed by:

- (a) The resident; and
- (b) The adult family home.

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

Based on interview and record review, the home did not ensure that a current inventory of personal belongings was present in the resident record for 3 of 6 residents (Resident #1, #2, and #3). Failure to ensure that a current inventory was present and signed in the resident record had the potential to result in losses to the resident, disagreements over ownership of items and disputes about whether certain belongings were ever present in the home.

**Findings include:**

On 6/1/16, a review of resident records revealed that Resident #1, #2, and #3 had no belongings inventories in their records at the home.

Resident #1 had a diagnosis of [REDACTED] but was observed to be alert and oriented.

Residents #2 and #3 both had a diagnosis of [REDACTED] which was in the more advanced phase. Neither Resident #2 or #3 would be expected to remember their belongings.

The Provider said she thought she had inventories in various stages of development for each resident.

**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, PINEHURST HOME is or will be in compliance with this law and / or regulation on (Date) 7/27/2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Evelyn Andwate  
Provider (or Representative)

7/27/2016  
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 interview and record review, the home did not ensure that the negotiated care plan for 1 of 2 sample residents (Resident #2) had a signature. Failure to ensure that a negotiated care plan had a signature from the resident/resident representative is a failure to secure consent for

RECEIVED  
AUG 03 2016  
SHS/ALISA/RCS

the procedures used by the home and to ensure resident preferences were considered.

Findings include:

On 6/1/16, a review of Resident #2's combined assessment/care plan dated 2/18/16 revealed there was no signature from Resident #2's representative. Further review revealed there was no signature from Resident #2's representative for the 2015 assessment/care plan either. The last signature by the Provider on any of Resident #2's care plans was dated 2/25/15 for the 2015 review.

The Provider said she had reminded the representative on several occasions. However, there was no documentation in the home detailing these efforts.

**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, PINEHURST HOME is or will be in compliance with this law and / or regulation on (Date) 6/2/2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Evelyn Anduate  
Provider (or Representative)

7/27/2016  
Date

RECEIVED  
AUG 03 2016  
DSHS/ALISA/RCS

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

- (1) The care and services identified in the negotiated care plan.
- (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 interview and record review, the home did not ensure that care identified in the resident's negotiated care plan was provided for 3 of 6 residents (Resident #2, #3, and #4). Failure to ensure that needed care and services was completed as planned had the potential to result in harm due to a lack of follow-through.

Findings include:

On 6/1/16, a review of resident records revealed Resident #2 was admitted to the home on [REDACTED] 16. Resident #2 had a combined assessment/care plan dated 3/14/16. Resident #2's assessment/care plan specified that monthly weights were to be taken and recorded. However, there was no record in the home of any weights being taken on Resident #2.

Resident #3 had a diagnosis of [REDACTED] and had "as needed" medications which required nursing oversight. Among these 'as needed' medications were a [REDACTED] 0.5 mg (milligram(s)) and medications for pain (i.e. [REDACTED] 50 mg; [REDACTED])

325mg). Resident #3 had a combined assessment/care plan dated 2/18/16 which stated that nurse delegation was required. On 6/1/16, a review of nurse delegation visits to the home revealed that the last delegation visit for Resident #3 was 11/24/15. The Provider was unable to locate any visit paperwork for February or for May 2016 for nurse delegation for Resident #3.

Resident #4 had a diagnosis of [REDACTED] and was unable to make her needs known. Resident #4 had a [REDACTED] injury for which she had a prescription for pain medications as well as an order to crush her medications. Resident #4's assessment dated 3/23/16 stated that nurse delegation was required. The last nurse delegation visit paperwork for Resident #4 in the home was dated 2/23/16. There was no visit summary found for any nurse delegation visit for Resident #4 in May.

The Provider was unable to say with certainty whether any of the above expected visits had occurred and did not indicate that any communication had been made with the nurse delegator before this licensing visit.

#### 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, PINEHURST HOME is or will be in compliance with this law and / or regulation on (Date) 6/3/2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Evelyn Andriate  
Provider (or Representative)

7/27/2016  
Date

RECEIVED  
AUG 03 2016  
DSHS/ALTS/RCS

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

- (2) When providing medication assistance or medication administration for any resident, the home must ensure each resident:
- (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 1 of 2 sample residents (Resident #2) received a prescribed medication as ordered and the medication log was accurate. These failures had the potential to result in unnecessary side effects and possible harm to Resident #2.

#### Findings include:

On 6/1/16, a review of Resident #2's medications revealed that Resident #2 had a prescription for a [REDACTED] spray, [REDACTED] 50 mcg (microgram(s)), to be given as "2 sprays in each [REDACTED] daily". A review of the medication log for Resident #2 showed the [REDACTED] was given 3 times a day, at 8 a.m., 12 p.m., and 5 p.m. The medication log was signed and showed Resident #2 received three times the prescribed dosage for April, and May of 2016. (The medication record for March, when Resident #2 had been admitted could not be located).

According to 'drugs.com', [REDACTED] is a corticosteroid with immunosuppressant characteristics, whose maximum effective dosage is 2 sprays per [REDACTED] per day. Strong adverse side effects can result when used in combination with other medications. The website further detailed because this medication can result in a weakened immune system, it can result in a greater chance of getting infections, such as: tuberculosis (TB), [REDACTED] herpes simplex infections, and infections caused by fungi, bacteria, viruses, and parasites. Symptoms of an infection may include: fever, pain, aches, feeling tired, nausea, vomiting, and chills.

On 6/1/16, Resident #2 was observed wearing a quilted jacket on a warm day with an expected high of 80 degrees Fahrenheit. When this Licensor remarked on this, Caregiver A stated that Resident #2 "is always cold". The Provider also later confirmed this statement. It is not known if this matter is related to the resident's possibly compromised immune status.

The Provider did not say, nor was there any documentation in the home of any inquiries made on behalf of Resident #2 clarifying the dosage for this medication.

Further, a comparison of Resident #2's current medication log and the medications on the physician's list dated 3/17/16 revealed that there were medications which Resident #2 was receiving without a prescription and medications that were prescribed, but were not on the medication log. The following discrepancies were noted:

[REDACTED] 5 mg(milligram(s)) given to the resident in the evening, but was not listed on the physicians list;

[REDACTED] with [REDACTED] was on the physician's list, but not on the medication log;

[REDACTED] was on the physician's list, but not on the medication log;

[REDACTED] 10mg, and [REDACTED] medication, was on the physician's list, but not on the medication log.

There were no additional prescriptions in the resident's record to show added or discontinued medications that would indicate the physician's list was not current. There was no documentation in the home indicating that any inquiries had been made on behalf of Resident #2 in regard to these discrepancies nor did the Provider make any indication of being aware of these discrepancies before this licensing visit. (Also see WAC 388-76-10475 Medication Log.)

#### 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, PINEHURST HOME is or will be in compliance with this law and / or regulation on (Date) 6/3/2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Guekyu Andrade  
Provider (or Representative)

7/27/2016  
Date

RECEIVED  
JUN 09 2016  
DSS/ALSA/RCS

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

- (1) Keep an up-to-date daily medication log for each resident except for residents assessed as medication independent with self-administration.
- (2) Include in each medication log the:
  - (b) Name of all prescribed and over-the-counter medications;

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

Based on interview and record review, the home did not ensure that the medication log for 1 of 2 sampled residents (Resident #2) was accurate. Failure to ensure that all medications for the resident were included on her medication log and accurate had the potential to lead to medication errors and omissions.

## Findings include:

On 6/1/16, a comparison of Resident #2's current medication log and the medications on the physician's list dated 3/17/16 revealed that there were medications which Resident #2 was receiving without a prescription and medications that were prescribed, but were not on the medication log.

There were no additional prescriptions in the resident's record to show added or discontinued medications that would indicate the physician's list was not current.

According to Resident #2's medication record, a [REDACTED] 5 mg(milligram(s)) was given to the resident in the evening. This medication was not listed on the physician's list of current medications (also see WAC 388-76-10430).

Additionally, a prescription for [REDACTED] with [REDACTED] an additional [REDACTED] prescription; and an [REDACTED] medication [REDACTED] (10mg) were present on the physician's list but were not present on the medication log for Resident #2.

There was no documentation in the home indicating that any inquiries had been made on behalf of Resident #2 in regard to these discrepancies nor did the Provider make any indication of being aware of these discrepancies before this licensing visit.

**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, PINEHURST HOME is or will be in compliance with this law and / or regulation on (Date) 7/27/2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

*Erin Anderson*  
Provider (or Representative)

7/27/2016  
Date

RECEIVED  
JUL 27 2016  
DEHS/ALTSARCS

**WAC 388-76-10480 Medication organizers. The adult family home must ensure:**

- (2) Prescribed and over-the-counter medications placed in a medication organizer come from the original container labeled for the resident by the pharmacist or pharmacy service;
- (3) Each resident and anyone giving care to a resident can readily identify medications in the medication organizer;
- (4) Medication organizer labels clearly show the following:
  - (a) The name of the resident;
  - (b) A list of all prescribed and over-the-counter medications;
  - (c) The dosage of each medication;
  - (d) The frequency which the medications are given.

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

Based on observation, record review and interview, the home did not ensure that a medication organizer for 1 of 1 residents (Resident #2) using a medication organizer was appropriately labeled and that one of the resident's medication had an original pharmacy/pharmacy services label. Failure to ensure that the medication organizer and medication container were properly labeled had the potential to result in medication errors that might go undetected by the staff of the home.

**Findings include:**

On 6/1/16, a review of medications revealed that a family member had an alarmed medication organizer for Resident #2's medications. The alarmed medication organizer could not be opened prior to the appointed medication time and was not transparent so that the accuracy of the any medications included could not be checked. The Provider stated that at the appointed time for medications to be taken, an alarm sounds on the medication organizer and the lid opens with the medications for that time are made available to the resident.

Resident #2's alarmed medication organizer had no label on it with her name, her medications, their dosages and times to be taken. There was no way for staff of the home to know whether Resident #2 was getting all her required medications in the correct dosages by reviewing the organizer. Additionally, it was not possible to say with any certainty whether Resident #2 had all her required medications included by reviewing the resident's medication log, which was not accurate as matched against the physician's list of 3/2016 (see cite under WAC 388-76-10475 (2) (b) included in this report).

The Provider said she was not aware that the medication organizer had to be labeled.

Further, a review of a physician's list of current medications for Resident #2 dated 3/17/16 revealed no reference to a [REDACTED] which was present in the resident's medication storage bin. [REDACTED] 5 mg was listed on Resident #2's medication log in the home and was signed as having been given to her through the months of April and May 2016. There was no pharmacy label on the [REDACTED] bottle.

The Provider did not say nor was there any documentation in the home of any inquiries on behalf of Resident #2 regarding any physician's approval for this medication or any potential interactions with Resident #2's other medications.

RECEIVED  
AUG 03 2018  
DSS/ALTS/RCS

**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, PINEHURST HOME is or will be in compliance with this law and / or regulation on (Date) 7/27/2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Suebyn Adewale  
Provider (or Representative)

7/27/2016  
Date

**WAC 388-76-10650 Medical devices. Before the adult family home uses medical devices for any resident, the home must:**

- (1) Review the resident assessment to determine the resident's need for and use of a medical device;
- (2) Ensure the resident negotiated care plan includes the resident use of a medical device or devices; and
- (3) Provide the resident and family with enough information about the significance and level of the safety risk of use of the device to enable them to make an informed decision about whether or not to use the device.

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

Based on interview and record review, the home did not ensure that 1 of 1 resident (Resident #6) using a [REDACTED] on her bed had needed documentation in place for its use. Failure to ensure that usage of the device was needed, safe, and the resident and her family had sufficient information to make an informed decision had the potential to expose Resident #6 to harm.

**Findings include:**

On 6/1/16, a tour of the home revealed that Resident #6 had a [REDACTED] on her bed. Resident #6 stated in an interview that she had the [REDACTED] her bed.

The Provider said Resident #6 needed the [REDACTED] of the bed.

A review of Resident #6's combined assessment/care plan revealed no mention of a need for the [REDACTED]. There was no risk assessment or safety plan. There was no documentation that any information had been provided to the resident or her representative regarding the risks, benefits or alternatives to use of the [REDACTED].

RECEIVED  
AUG 03 2016  
DSHS/ALTS/RCS

**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, PINEHURST HOME is or will be in compliance with this law and / or regulation on (Date) 7/27/2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Guelyn Andwate

Provider (or Representative)

7/27/2016

Date

RECEIVED  
AUG 09 2016  
DSHS/ALTS/RCS