



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 #: 750807	Completion Date
Plan of Correction	BLUEBIRD BUNGALOW	January 21, 2016
Page 1 of 6	Licensee: AMBROSE ELDER	

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:
 1/20/2016

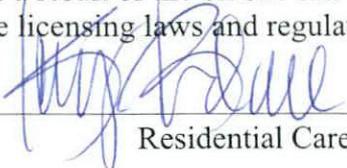
BLUEBIRD BUNGALOW
 13606 25TH AVE SE
 MILL CREEK, WA 98012

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

RECEIVED
 FEB 18 2016
 AMS/NRCS
 Shady Point

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

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.


 Provider (or Representative)

2/10/16
 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 observation, 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 observation, record review, and interview occurred on 1/20/16 unless otherwise noted.

Interview with Caregiver A revealed she was hired on 9/20/14. Interview with the provider revealed Caregiver B (the provider's daughter) had been working in the home since it opened in 2008, Caregiver C was hired on 11/15/15, and Caregiver D was hired on 11/29/15.

Record review revealed the required orientation document was not found in any of the caregiver's records. There was a form called "Orientation Addendum" in Caregiver A's file; however, it did not include all required information (including date of hire, date of orientation, hours of the training, etc.). During an interview, the provider said she remembered filling out the orientation forms for her staff. The provider said she may have given the orientation forms to staff (instead of keeping them in the records at the adult family home). When asked, Caregiver A said she would look in her personal file to see if she had a copy.

PHW - OVER →

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, BLUEBIRD BUNGALOW is or will be in compliance with this law and / or regulation on (Date) 3/1/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Helen Ambrose
 Provider (or Representative)

X 2/12/16
 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 388-76-10475 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;
 - (3) Ensure the medication log includes:
 - (c) Documentation of any changes or new prescribed medications including:
 - (iii) A logged call requesting written verification of the change; and

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 4) met all laws and rules relating to medications, all medications were given as ordered, and the medication log was up-to-date. This failure placed the resident at risk of medication errors.

Findings include:

All observation, record review and interview occurred on 1/20/16 unless otherwise noted.

Resident 4 was admitted to the home on 11/9/12 with medically disabling diagnoses including [REDACTED] and recent hospitalization secondary to [REDACTED] and status post surgery. The resident was on multiple medications. Observation of the resident's medication supply and review of the doctor's orders and medication log revealed:

Plaw over →

-- [REDACTED] 5% Patch: The doctor's order read, "Apply 1 patch to a clean dry area every 72 hours. Leave patch on for 60 hours, then remove." The entry on the medication log read, [REDACTED] 5 % 1/2 to 1 patch for 12 hours on as needed (PRN) for [REDACTED] pain". There was no evidence this medication had been given as ordered since she was discharged from the hospital on [REDACTED] 6. When asked, the provider had not realized the discrepancy on the instructions between the doctor's order and the medication log; thus, she had not contacted the doctor for verification. The provider said she had not been applying the [REDACTED] patch as ordered.

[REDACTED] PRN: This medication was listed on the medication log; however, there was no doctor's order for this medication to be used PRN.

[REDACTED] PRN: This medication was listed on the medication log; however, there was no doctor's order for this medication to be used PRN. When asked, the provider said the resident did not need to use this medication.

[REDACTED] PRN: This medication was listed on the medication log; however, there was no doctor's order for this medication to be used PRN.

[REDACTED]: There was no order for this medication and it was not listed on the medication log; however, there was a tube of [REDACTED] in the resident's medication container. When asked, the provider said she had been giving this medication to the resident twice daily without charting it.

During an interview, the provider said Resident 4's medication orders must have changed when she was discharged from the hospital. The provider acknowledged she should have noted the changes in medication orders, documented the changes on the medication log, and applied the [REDACTED] as ordered. The provider said she would contact the doctor to verify the [REDACTED] order soon.

On 1/21/16, the licenser received a fax from the provider. Review of the faxed document revealed the provider had sent a fax to the doctor to verify the Lidoderm Patch. The provider also made corrections on the medication log to include current medications ordered for the resident.

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Helen Ambrose
Provider (or Representative)

2/12/16
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 2 of 2 sampled residents (Resident 1,4) received a notice of services (admission agreement/ contract) 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 1/20/16 unless otherwise noted.

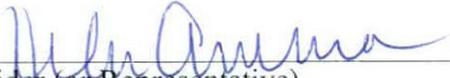
Record review revealed Resident 1 was admitted to the home on [redacted] 13 and he had a power-of-attorney (POA) who signed for him. Resident 4 was admitted to the home on [redacted] 12. She did not sign for herself. She had a POA who signed for her.

Record review revealed both residents had been residing in the home for more than 24 months and there was no evidence the residents or their POAs had received/ signed a new or updated contract since admission. When interviewed, the provider said she would give the residents' POAs a copy of the admission agreement to sign and date soon.

PLAN OVER ->

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Provider (or Representative)

 Date

PLAN - ORIENTATION -

All required ORIENTATION Forms / DOCUMENTATION
Completed + placed in employee files following
their ORIENTATION of Facility + Residents.
IT will contain the 6 items listed

Medication Plan:

Hospital Discharge orders - Double check

Hospital orders to Medication Record using (✓). Reviewing more carefully. Especially writing

PRNS + other medications not listed are added. Will continue to fax discharge orders to MD + follow up with SIS + clarifications.

I will be + am more aware of the variations of discharge orders from Hospitalists, ER, MD visits etc.

3 Plan
Admission agreement.

ADD to Admission check list:

Admission agreement review 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

April 4, 2016

AMBROSE ELDER CARE LLC
BLUEBIRD BUNGALOW
19238 181ST AVE NE
WOODINVILLE, WA 98077

RE: BLUEBIRD BUNGALOW License #750807

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on March 29, 2016 for the deficiency or deficiencies cited in the report/s dated January 21, 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