



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 98907, Lakewood, WA 98496

May 12, 2016

Marilyn A Dvorak
Puyallup Adult Family Home
9904 118th St E
Puyallup, WA 98373

RE: Puyallup Adult Family Home License #751160

Dear Provider:

On May 11, 2016 the Department completed a review of communication and / or documents from you indicating that you have corrected the deficiency or deficiencies cited in the report/s dated March 9, 2016 and April 20, 2016.

Based on the review of this information the Department finds the deficiency or deficiencies have been corrected. Your home meets the adult family home licensing requirements.

The Department staff who did the off-site verification:
Jane Chantler, Complaint Investigator

If you have any questions please, contact me at (253) 983-3826.

Sincerely,

A handwritten signature in black ink, appearing to read "Lisa Cramer".

Lisa Cramer, Field Manager
Region 3, Unit A
Residential Care Services



STATE OF WASHINGTON
 DEPARTMENT OF SOCIAL AND HEALTH SERVICES
 AGING AND LONG-TERM SUPPORT ADMINISTRATION
 PO Box 98907, Lakewood, WA 98496

RECEIVED
 MAY 02 2016
 DSHS RCS Region 3

Statement of Deficiencies	License #: 751160	Completion Date
Plan of Correction	Puyallup Adult Family Home	April 20, 2016
Page 1 of 2	Licensee: Marilyn A. Dvorak	

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 follow-up inspection of: 4/13/2016

Puyallup Adult Family Home
 9904 118th St E
 Puyallup, WA 98373

This document references the following SOD dated: March 9, 2016

The department staff that inspected the adult family home:
 Jane Chantler, RN, BSN, Complaint Investigator

From:
 DSHS, Aging and Long-Term Support Administration
 Residential Care Services, Region 3, Unit A
 PO Box 98907
 Lakewood, WA 98496
 (253)983-3826

As a result of the on-site follow-up 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

4/26/16

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)

4-29-16

Date

04/29
 08/20

WAC 388-76-10161 Background checks Who is required to have.

(2) The adult family home must ensure that all caregivers, entity representatives, and resident managers who are employed directly or by contract after January 7, 2012, have the following background checks:

(b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on interview and record review the adult family home failed to ensure one currently employed caregiver (Staff A) had a completed national fingerprint background check. This failure placed residents at risk of being cared for by staff who had a disqualifying crime.

Findings include:

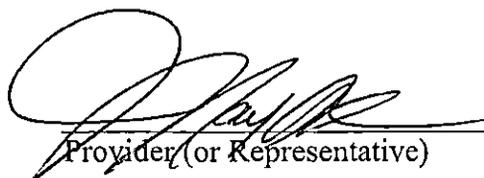
Record review of Staff A's qualifications revealed she was hired as a caregiver on 6/1/2015. Staff A had a completed Washington State name and birthdate background investigation result report dated 3/27/14, but had not completed a national fingerprint background check.

In an interview on 4/13/15, the Provider stated she told Staff A to get her fingerprints checked so she went to a local police station to have this done, but was unable to get this completed there. This licenser directed the Provider to access information on the Department's website regarding background investigations and how to request a background check with fingerprints. The Provider acknowledged she had been unclear about the process required to get fingerprint backgrounds completed.

This is a repeated deficiency previously cited on 3/9/16.

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, Puyallup Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 4/29/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.



Provider (or Representative)

Date



STATE OF WASHINGTON
 DEPARTMENT OF SOCIAL AND HEALTH SERVICES
 AGING AND LONG-TERM SUPPORT ADMINISTRATION
 PO Box 98907, Lakewood, WA 98496

Statement of Deficiencies	License #: 751160	Completion Date
Plan of Correction	Puyallup Adult Family Home	March 9, 2016
Page 1 of 6	Licensee: Marilyn A. Dvorak	

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:
 3/9/2016

Puyallup Adult Family Home
 9904 118th St E
 Puyallup, WA 98373

The department staff that inspected the adult family home:
 Jane Chantler, RN, BSN, Complaint Investigator

From:
 DSHS, Aging and Long-Term Support Administration
 Residential Care Services, Region 3, Unit A
 PO Box 98907
 Lakewood, WA 98496
 (253)983-3826

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
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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
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4/15
 S/S

WAC 388-76-10161 Background checks Who is required to have.

(2) The adult family home must ensure that all caregivers, entity representatives, and resident managers who are employed directly or by contract after January 7, 2012, have the following background checks:

(b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure that two caregivers (Staff C, Staff D) hired since 2012 had completed a national fingerprint background check. This failure placed residents at risk of being cared for by staff who had a disqualifying crime. Findings include:

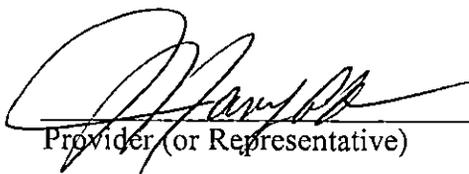
Record review of Staff C's qualifications revealed that she was hired as a caregiver on 4/14/14. Staff C had a completed Washington State name and birthdate background investigation result report dated 3/27/14, but had no completed national fingerprint background check.

Record review of Staff D's qualifications revealed that she was hired as a caregiver on 6/1/2015. Staff D had a completed Washington State name and birthdate background investigation result report dated 5/19/2015, but had no completed national fingerprint background check.

In an interview on 3/9/16, the Provider stated Staff D recently moved out of state and was no longer employed at the facility. The Provider acknowledged that Staff C and Staff D did not have fingerprint background checks. She stated she was not familiar with the fingerprint process so the two staff hired since 2012 had completed the Washington State name and birthdate background checks and not the required fingerprints checks.

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, Puyallup Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 4/15/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.


 Provider (or Representative)

4/8/16
 Date

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:
 - (a) Name of the resident;
 - (b) Name of all prescribed and over-the-counter medications;
 - (c) Dosage of the medication;
 - (d) Frequency which the medications are taken; and

- (e) Approximate time the resident must take each medication.
- (3) Ensure the medication log includes:
- (c) Documentation of any changes or new prescribed medications including:
- (i) The change;
 - (ii) The date of the change;
 - (iii) A logged call requesting written verification of the change; and
 - (iv) A copy of written verification of the change from the practitioner received by the home by mail, facsimile, or other electronic means, or on new original labeled container from the pharmacy.

This requirement was not met as evidenced by:

Based on interview and record review the adult family home failed to keep an up-to-date medication log for two residents (#1, #2) that accurately listed all current medications. In addition, the adult family home failed to get verification from Resident #2's prescriber before discontinuing her eye drops. These failures caused the potential for medication errors to be made and residents to receive incorrect medications.

Findings include:

All interview and record review occurred on 3/9/16.

Resident #1 was admitted to the facility on [REDACTED] 2015 with diagnoses to include [REDACTED]. Record review of Resident #1's March 2016 medication log revealed an entry for [REDACTED] mg (anti-anxiety); take one tablet at night for a week. Staff had initialed giving this medication for 5 nights; 3/2/16 through 3/6/16. These initials had then been crossed through and the initials "dcd" (discontinued) written. Another entry said "After taking [REDACTED] mg for one week, then start [REDACTED] mg tablet take one table by mouth at night. Staff had initialed 6 doses given from 3/3/16 through 3/8/16. Since staff were initialing in both places it appeared that Resident #1 was getting a total of 7 mg of [REDACTED] for four of these nights.

In an interview with the Provider, she stated that on 3/3/16 she contacted Resident #1's medical subscriber as the resident had been awake all night after taking only 2 mg of [REDACTED]. The prescriber changed the prescription to 5 mg at bedtime. The Provider acknowledged she had not clearly entered the prescription change on the medication log making it seem like he had gotten 7 mg of [REDACTED] for some his evening doses, but had given the [REDACTED] correctly per the prescriber's orders.

Resident #2 was admitted to the facility on [REDACTED] 15 with diagnoses to include [REDACTED]. Resident #2 had a history of blood clots and was on anticoagulant therapy (blood thinning medication). On 12/15/15 Resident #2 was admitted to hospice services for a decline in her health and functioning.

Record review of Resident #2's March 2016 medication log revealed there were seven medications that were incorrect on the log as follows:

1. [REDACTED] 0.004% ophthalmic drops (used to treat glaucoma - increased pressure in the eye). This medication was listed as discontinued. Review of the record revealed no medical prescriber's order to verify this medication was no longer to be used. In an interview with the

Provider she stated that the family had directed her to discontinue this medication as they were not able to get her in to see her eye doctor. The Provider acknowledged that she had not requested verification from Resident #2's physician.

2. [REDACTED] mg (antipsychotic/mood stabilizer) twice a day was listed on the March medication log. On 12/15/15 this medication dose had been changed to 25 mg twice a day, but the new dosage was not listed on the current medication log.

3. Observation of Resident #2's medication supply revealed [REDACTED] mg tablets (antidepressant and for sleep); one at bedtime. Review of the March 2016 medication log revealed that this was not listed and signed off as given. The Provider stated that she was giving this to Resident #2 every night, but had not listed it on the medication log.

4. Observation of Resident #2's medication supply revealed [REDACTED] twice a day (anti-inflammatory pain medication). Review of the March 2015 medication log revealed that this was not listed and signed off as given. The Provider stated that she was giving this medication to Resident #2 every night but had not listed it on the medication log.

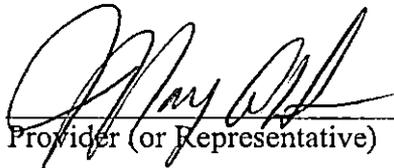
5. Review of the medication log revealed: [REDACTED] mg (anti-anxiety) take one tablet twice a day as needed for anxiety/agitation. On 3/7/16 the dose of this had been changed to [REDACTED] mg twice daily as needed for anxiety/agitation, but the medication log had not been updated to reflect this change.

6. Review of the medication log revealed: [REDACTED] mg (antidepressant) 1/2 tablet by mouth daily at bedtime. On 3/7/16 the dose of this had been changed to [REDACTED] mg one tablet at bed time, but the medication log had not been updated to reflect this change.

7. Review of the medical prescriber's order dated 3/8/2016 for [REDACTED] (blood thinning) medication stated to discontinue the previous [REDACTED] dose and start [REDACTED] mg every day. In addition start [REDACTED] mg, 1/2 tablet on Monday with the 5 mg tablet = 5.5 mg. Review of the March 2016 med log revealed two different dosing schedules for [REDACTED] one beginning 2/3/16 and the other beginning 2/18/16. In an interview the Provider stated Resident #2 had her blood drawn every week and then the [REDACTED] dose was changed. The Provider acknowledged she did not put the new dose on the medication log every time the dose changes.

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, Puyallup Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 4/15/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.



Provider (or Representative)

4-8-16

Date

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

- (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.
- (5) The person filling the medication organizer updates the labels on the medication organizer when the practitioner changes a medication.

This requirement was not met as evidenced by:

Based on interview and record review the adult family home failed to ensure that the medication organizer's label was updated when the practitioner changed medications for one resident (#2). This failure caused the potential for medication errors to be made and the resident to receive incorrect medications. Findings include:

Resident #2 was admitted to the facility on [REDACTED] 15 with diagnoses to include [REDACTED]. Resident #2 had a history of blood clots and was on anticoagulant therapy (blood thinning medication). On 12/15/15 Resident #2 was admitted to hospice services for a decline in her health and functioning.

Observation of Resident #2's medication supply revealed she had medications packaged in bubble packages, bottles and some medications in a medication organizer that was provided by a local pharmacy.

In an interview with the Provider on 3/16/16, she stated the pharmacy delivered some of her medications packaged in a medication organizer every two weeks. In addition, some of her medications were prescribed by hospice and came from another pharmacy.

Record review of Resident #2's medication organizer revealed incorrect labeling for four medications as follows:

1. [REDACTED] mg (antipsychotic/mood stabilizer) twice a day was listed on the March med log. On 12/15/15 this medication dose had been changed to 25 mg twice a day, but the new dosage was not listed on the current medication organizer.

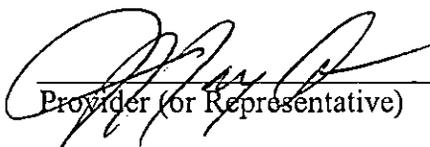
2. Review of the medication organizer label read: [redacted] mg (anti-anxiety) take one tablet twice a day as needed for anxiety/agitaion. On 3/7/16 the dose of this had been changed to [redacted] mg twice daily as needed for anxiety/agitaion, but the organizer label had not been updated to reflect this change.

3. Review of the medication organizer label read: [redacted] mg , one daily. Record review revealed a prescriber's order dated 12/15/15 revealed this medication had been discontinued. This medication was still listed by the pharmacy and supplied by the pharmacy. In an interview the provider stated she was holding this out and sending these tablets back to the the pharmacy in the medication organizer.

4. Review of the medication organizer label read: [redacted] mg twice a day. This label had not been updated to reflect the new change to [redacted] mg three times a day by the prescriber on 12/15/15.

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, Puyallup Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 4/15/16 . In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.



Provider (or Representative)

4-8-16

Date