



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 #: 752644	Completion Date
Plan of Correction	Adonai West AFH LLC	January 27, 2016
Page 1 of 10	Licensee: Adonai West AFH LLC	

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:
 1/26/2016

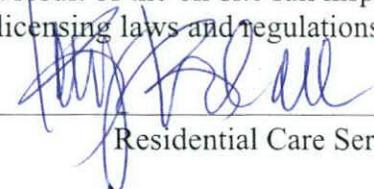
Adonai West AFH LLC
 20630 S Danvers Rd
 Lynnwood, WA 98036

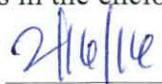
RECEIVED
 FEB 26 2016
 AD. L. B. B. S.
 Shirley Hunt

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

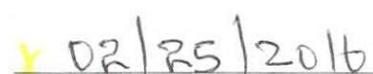
As a result of the on-site full inspection the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.


 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 388-76-10355 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:

(7) If needed, a plan to:

(c) Respond to resident's special needs, including, but not limited to medical devices and related safety plans;

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 observation, record review, and interview, the provider failed to have a system in place to ensure all the required documentation for the use of the side rail was completed for 1 of 4 residents (Resident ■). This failure placed the resident at risk of harm from entrapment.

Findings include:

All observation, record review, and interview occurred on 1/26/16 unless otherwise noted.

Record review revealed Resident ■ was admitted to the home on ■ 15 with medically disabling diagnoses including ■

■ The resident could communicate his needs, but was unable to sign for himself. He had a power-of-attorney (POA) to sign documents for him.

During a tour of the home, the licenser noted there was a 1/2 bed rail on the ■ side of the resident's bed. Record review revealed there was no documentation to indicate the provider had discussed the risks and benefits of the using the bed rail with the resident or his POA. There was no evidence a safety assessment had been conducted prior to using the bed rail and there were no care directives in the negotiated care plan for caregivers to follow.

When asked, the provider said the bed rail came with the bed when the resident moved in, but it had always been "down" and the resident did not use the bed rail at all. The provider said she would ask Caregiver B to remove it from the bed soon.

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, Adonai West AFH LLC is or will be in compliance with this law and / or regulation on (Date) 02/25/2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

A. Banno
Provider (or Representative)

02/25/2016
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.
- (3) Ensure the medication log includes:
 - (a) Initials of the staff who assisted or gave each resident medication(s);
 - (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 record review and interview, the provider failed to have a system in place to ensure services provided for 2 of 2 sampled residents (Resident 1, 3) met all laws and rules relating to medications. This failure placed the residents at risk of medication errors.

Findings include:

All record review, and interview occurred on 1/26/16 unless otherwise noted.

RESIDENT 1:

The resident was admitted to the home on [REDACTED] 5 with medically disabling diagnoses and he was on multiple medications. Review of the physician orders and medication log revealed:

[REDACTED] mg): The order said to give this medication daily and the entry on the medication log matched the doctor's order; however, staff's initials on the medication log indicated this medication was given 3 times a week. When interviewed, the provider said she administered this medication three times a week because the resident was on a bowel program on Monday, Wednesday, and Friday. The provider said she would contact the doctor soon to obtain an order to change from "everyday" to "three times a week on Monday, Wednesday, and Friday."

-----Acetaminophen (500 mg/ tablet): The order said to give 1-2 tablets every 6 hours as needed (PRN). Documentation on the medication log showed the provider/ staff had been giving this medication everyday; however, there was no charting on the back side of the medication log to indicate the time, dosage (1 or 2 tablets) given, reason, and effectiveness. When asked, the provider said two tablets were given everyday at 8 PM and she did not have a doctor's order to give this medication routinely in order to not do the additional charting on the back side of the medication log.

RESIDENT 3:

The resident was admitted to the home on [REDACTED] 15 with medically disabling diagnoses and he was on multiple medications.

Review of the physician orders and medication log revealed:

[REDACTED] mg): The order said to give this medication everyday and notify the doctor if the [REDACTED] was greater than 160 or less than 90, and the [REDACTED] was greater than 90 and less than 50. Review of the vital sign log revealed staff had not been consistent in checking the [REDACTED]. When interviewed, the provider said she would make sure she and staff checked the resident's [REDACTED] everyday.

-----Acetaminophen (500 mg): The order said to give 1 tablet every six hours as needed. Documentation on the medication log showed staff had been administering this medication twice daily; however, PRN charting on the back of the medication log had not been consistent. No PRN charting for four doses given between 1/6 and 1/9/16. When interviewed, the provider acknowledged the inconsistent PRN charting and said she would make sure to chart appropriately when giving PRN medications from now on.

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A. Bauer
Provider (or Representative)

02/25/2016
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:

(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 1 of 4 residents (Resident 1) or his representative had signed and dated the home's written policy on accepting Medicaid as a payment source, as required.

Findings include:

All record review, and interview occurred on 1/26/16 unless otherwise noted.

Record review revealed Resident 1 was admitted to the home on [REDACTED] 15 with medically disabling diagnoses including [REDACTED]. The resident could communicate his needs, but was unable to sign for himself. He had a power-of-attorney (POA) to sign documents for him.

Record review revealed the home's Medicaid policy had not been signed and dated by the POA. When interviewed, the provider was surprised to see the Medicaid policy in the resident's record had not been signed and dated. The provider said she would contact the POA and obtain the required signature and date for the document as soon as possible.

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A. B. [Signature]
Provider (or Representative)

02/25/2016
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
 - (b) A copy of all complaint investigation reports, and any related cover letters received since the most recent inspection or not less than the last twelve months.
- (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 latest inspection results were available in a visible location where they could be examined by anyone interested without having to ask for them. In addition, there was no notice posted in the home to indicate inspection and complaint investigation reports from the previous three years were available upon request, as required.

Findings include:

All observation and interview occurred on 1/26/16 unless otherwise noted.

During a tour of the home, the licenser noted there was a black binder (labeled inspection report) on top of the organ in the living room. There was only a follow-up letter dated 9/15/14 in the binder. There was no notice to indicate past inspection and complaint investigation reports were available upon request.

When interviewed, the provider said she did not know she had to keep the entire inspection results available in the visible location. The provider said she would put the latest inspection results in the inspection binder and post a notice regarding previous inspection and complaint investigation reports soon.

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A. Baur
Provider (or Representative)

X 02/25/2016
Date

WAC 388-76-10725 Electronic monitoring equipment Resident requested use.

- (2) If the resident requests audio or video monitoring, before any electronic monitoring occurs the home must ensure:
- (d) The resident and the home have agreed upon a specific duration for the electronic monitoring documented in writing.
- (3) The home must:
- (a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and
- (b) Have each reevaluation in writing signed and dated by the resident.
- (6) For the purposes of consenting to audio electronic monitoring, the term "resident includes only:
- (b) The resident's court-appointed guardian or attorney-in-fact who has obtained a court order specifically authorizing the court-appointed guardian or attorney-in-fact to consent to audio electronic monitoring of the resident.
- (7) If the resident's decision maker consents to audio electronic monitoring as specified in subsection (6) above, the home must maintain a copy of the court order authorizing such consent in the resident's record.

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 proper authorization for audio monitoring for 1 of 4 residents (Resident 1). This failure placed the resident at risk of violation of his privacy rights.

Findings include:

All observation, record review, and interview occurred on 1/26/16 unless otherwise noted.

Record review revealed Resident 1 was admitted to the home on [REDACTED] 15 with medically disabling diagnoses including [REDACTED]

[REDACTED] The resident was able to speak and communicate his needs to staff; however, he was unable to sign for himself. He had a power-of-attorney (POA) who signed for him.

During a tour of the home, the provider showed the licenser the location of the baby monitor in Resident 1's bedroom. It was placed on top of the bedside table. When interviewed, the provider

said she turned on the baby monitor at night. The provider said the resident had requested the use of the baby monitor and his POA had agreed with it. There was no evidence the resident had a court-appointed guardian to consent for the use of audio monitoring. Review of the resident's records revealed there was no written documentation indicating the resident and provider had agreed upon the a specific duration for the use of the baby (audio) monitor. There was no evidence the provider conducted quarterly reviews and had the reevaluation signed and dated as required by regulation.

During an interview, the provider said she was not aware of the regulation on the use of audio monitoring. The provider said she would stop using the baby monitor in Resident 1's bedroom until she was able to have proper authorization and documentation. The provider said she would make sure to have awake night staff to meet the resident's needs during the night.

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A. Baum

Provider (or Representative)

02/25/2016

Date

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

- (1) Keep the home both internally and externally in good repair and condition with a safe, comfortable, sanitary, homelike environment that is free of hazards;
- (3) Provide clean, functioning, safe, adequate household items and furnishings to meet the needs of each resident;

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 internal environment was clean, sanitary, and in good repair. This failure placed the residents at risk of a diminished quality of life.

Findings include:

All observation and interview occurred on 1/26/16 unless otherwise noted.

During a tour of the home with the provider, the licensor made the following observation:

-----There was a strong urine odor in the living room and in the bedroom occupied by 1 of 4 resident (Resident [REDACTED])

-----There was a large amount of laundry detergent scattered on top of the washer.

-----The paint on the wood panel (separating the bathroom floor and shower floor) was peeling. When asked, the provider said wheels on the wheelchairs caused the paint to peel. The provider

said she would look for a transition strip at a hardware store to replace the wood panel.
-----There was fecal matter on the toilet seat in one of the resident bathrooms. When asked, the provider said a resident had just finished using the bathroom.
-----The caulking around the base of the shower stall in both resident bathrooms needed to be cleaned. There was brown and black organic matter on the caulking.

During an interview, the provider said she would make sure to keep the home clean and sanitary.

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A. Baur
Provider (or Representative)

02/25/2016
Date

WAC 388-112-0165 Who is required to complete specialty training, and when? If an assisted living facility or adult family home serves one or more residents with special needs, long-term care workers in those settings must complete specialty training and demonstrate competency.

- (1) If the specialty training is integrated with basic training, long-term care workers must complete the specialty training within one hundred twenty days of hire.
- (3) Until competency in the specialty training has been demonstrated, long-term care workers may not provide personal care to a resident with special needs without direct supervision in an assisted living facility or in an adult family home.

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 1 of 2 caregivers (Caregiver A) completed the specialty trainings in dementia and mental health within one hundred twenty days of hire, as required.

Findings include:

All observation, record review, and interview occurred on 1/26/16 unless otherwise noted.

The home was licensed to provide specialty care for residents with dementia and mental health. Record review revealed 2 of 4 residents (Resident 3, 4) had care needs related to dementia, and 1 of 4 residents (Resident 2) had care needs related to mental health.

Caregiver A was on duty during the inspection. When interviewed, Caregiver A said she had been working in the home since 8/11/14. Record review revealed Caregiver A had two certificates for Population Specific Trainings in dementia and mental health. She did not have certificates to indicate she had obtained the specialty trainings in dementia and mental health.

Attestation Statement

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A. Baruch
Provider (or Representative)

02/25/2016
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
- (d) Continuing education must include one-half hour per year on safe food handling in adult family homes described in RCW 70.128.250 .

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 she completed the required annual food safety training, as required.

Findings include:

On 1/26/16, record review revealed the provider's food worker card had expired on 12/6/15. When interviewed, the provider said she did not realize her food safety training had expired already. The provider said she would obtain the training again soon.

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, Adonai West AFH LLC is or will be in compliance with this law and / or regulation on (Date) 02/25/2016 . In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

A. Baruch
Provider (or Representative)

02/25/2016
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

Adonai West AFH LLC
Adonai West AFH LLC
20630 S Danvers Rd
Lynnwood, WA 98036

RE: Adonai West AFH LLC License #752644

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on March 25, 2016 for the deficiency or deficiencies cited in the report/s dated January 27, 2016 and found no deficiencies.

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

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

Sincerely,

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