

03/01/16
Ombud



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Avenue, Suite#220, Vancouver, WA 98684

Statement of Deficiencies	License #: 753001	Completion Date
Plan of Correction	Aquila Adult Family Home	February 23, 2016
Page 1 of 5	Licensee: Aquila Adult Family	

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: 2/18/2016

Aquila Adult Family Home
7601 AQUILLA CT
VANCOUVER, WA 98682

The department staff that inspected the adult family home:
Sarah Bjork, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3, Unit E
800 NE 136th Avenue, Suite#220
Vancouver, WA 98684
(360)397-9549

RECEIVED
MAR 11 2016
DSHS/ADSA/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.

C. Quinsky for Hazel Ramsey
Residential Care Services

03/01/2016
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.

[Signature]
Provider (or Representative)

3/7/2016
Date

afb
3/22/16

✓ 04/08/16

WAC 388-76-10181 Background checks Employment Nondisqualifying information.

(1) If any background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not disqualifying under chapter 388-113 WAC, then the adult family home must:

- (a) Determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care; and
- (b) Document in writing the basis for making the decision, and make it available to the department upon request.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the provider failed to ensure one caregiver (Staff A) with non-disqualifying findings on his criminal background check had documentation of a character, competency and suitability review. Failure to ensure a suitability review was completed resulted in all four residents receiving care from a person who had not had the benefit of a formal review.

Findings include:

Observation, interview and record review took place on 2/18/2016.

Staff A was observed assisting residents and providing hands-on care. The provider stated she and Staff A lived in the adult family home. Staff A's criminal background check revealed two non-disqualifying findings which occurred in 2003 and 2008. No documentation of a character, competency and suitability review was noted. The provider stated she was unaware of the requirement and would complete one as soon as possible.

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, Aquila Adult Family Home is or will be in compliance with this law and / or regulation on (Date) May 31, 2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Per Interview
w/ Pro -
4/18/16
POC
date
SB

[Signature]
Provider (or Representative)

5/07/2016
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:

- (1) A list of the care and services to be provided;
- (2) Identification of who will provide the care and services;
- (3) When and how the care and services will be provided;
- (4) How medications will be managed, including how the resident will get their medications when the resident is not in the home;
- (7) If needed, a plan to:

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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the provider failed to ensure one sampled resident's (Resident #3) negotiated care plan contained information about Resident #3's care and service needs. Failure to ensure Resident #3's negotiated care plan contained all required information placed Resident #3 at risk for not having her care needs met.

Findings include:

Observation, interview and record review took place on 2/18/2016.

Resident #3 was admitted to the adult family home on [redacted] 2015 with diagnoses including [redacted]. Resident #3's assessment revealed Resident #3 was alert and oriented and able to make decisions. The assessment indicated Resident #3 required assistance with medications and was delegated for [redacted] and [redacted] medications. The assessment identified the need to monitor Resident #3's [redacted] and [redacted] weekly and to report if out of identified parameters. A review of Resident #3's medications revealed Resident #3 was prescribed a medication twice daily for [redacted] with a hold parameter (requiring Resident #3's [redacted] and [redacted] be checked before giving the medication and to hold the medication when the resident's [redacted] was less than 100 or [redacted] was less than 60). A side rail assessment dated 12/9/2015 was noted in Resident #3's chart.

During a tour of the home, a side rail was noted on Resident #3's bed. Eye drops and [redacted] (a [redacted] medication used to relieve pain and [redacted]) were observed on a table in Resident #3's bedroom.

Resident #3's negotiated care plan did not contain information about the need to check Resident #3's [redacted] or identify the need to hold medications when out of identified parameters. The care plan did not document information about the use of side rails or any interventions for safety and monitoring. The care plan did not include information about Resident #3 managing some of her medications independently in her room or any interventions to ensure they were maintained safely (see citation 388-76-10430).

Attestation Statement

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Handwritten initials: 4/18/16 and SR

Annopless
Provider (or Representative)

3/07/2016
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:
 - (a) Assessment indicates the amount of medication assistance needed by the resident;
 - (b) Negotiated care plan identifies the medication service that will be provided to the resident;
 - (c) Medication log is kept current as required in WAC 388-76-10475 ;
 - (d) Receives medications as required.

WAC 388-76-10485 Medication storage. The adult family home must ensure all prescribed and over-the-counter medications are stored:

- (1) In locked storage;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the provider failed to ensure medication needs were accurately identified, interventions were in place to address the needs, and medication logs were accurate and up-to-date for two of two sampled residents (Resident #2 and #3). Failure to ensure medication needs were addressed as required, and logs were accurate, placed both sampled residents at risk for not having their medication needs met.

Findings include:

Observation, interview and record review took place on 2/18/2016.

Resident #3 was admitted to the home with diagnoses including [REDACTED]. A review of Resident #3's medications revealed Resident #3 was prescribed 1/2 (25mg) tab of [REDACTED] twice daily with a hold parameter (requiring Resident #3's [REDACTED] and [REDACTED] be checked before giving the medication and to hold the medication when the resident's [REDACTED] was less than 100 [REDACTED] was less than 60). The provider stated Resident #3's [REDACTED] were checked twice daily before the medication was given but none of the vitals had been documented or tracked. As no logs or records were kept to document Resident #3's vitals, it was impossible to verify the medication was given as ordered.

During a tour of the home, eye drops and [REDACTED] medication used to relieve pain and [REDACTED] were observed on a table in Resident #3's bedroom. The medications were not stored securely to prevent unauthorized access. Resident #3's assessment revealed Resident #3 was alert and oriented, and able to make decisions. The assessment indicated Resident #3 required assistance with medications and was delegated for [REDACTED] and [REDACTED] medications. Resident #3's assessment and negotiated care plan did not include information about Resident #3's ability to manage some of her medications independently in her room. No interventions were identified in the documents addressing safe management of the medications (see citation 388-76-10355-7). The provider stated she would update the care plan and ensure the medications be stored securely.

Review of Resident #3's medication log revealed the [redacted] had not been added to the medication log. The log documented Resident #3 was prescribed one (100mg) tab of [redacted] daily and one (15mg) tab of [redacted] daily at bedtime. Review of the medication supply and orders revealed the resident was prescribed the [redacted] two times daily and the resident was to receive 1/2 tab (7.5mg) of [redacted] daily as needed for [redacted]

Resident #2 was admitted to the home with diagnoses including [redacted] Resident #2's medication log revealed he was prescribed 1/2 (25mg) tab of [redacted] twice daily for [redacted] with a hold parameter (requiring Resident #2's blood pressure and heart rate be checked before giving the medication and to hold the medication when the resident's systolic blood pressure was less than 100 or pulse was less than 60). The provider stated Resident #2's blood pressure and pulse were checked twice daily before the medication was given but none of the vitals had been documented or tracked. As no logs or records were kept to document Resident #2's vitals, it was impossible to verify the medication was given as ordered.

Resident #2's medication log contained three medications which had been discontinued or changed. Resident #2 had two as-needed pain medications [redacted] prescribed on 2/14/2016 which needed to be added to the medication log.

The provider stated she would correct the inaccuracies in the residents' medication logs, develop a system for tracking residents' vitals to ensure medications were given as ordered, and update documentation to reflect Resident #3's current medication needs and a plan for safe medication storage.

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, Aquila Adult Family Home is or will be in compliance with this law and / or regulation on (Date) May 31, 2016 . In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

4/18/16
SB

[Signature]
Provider (or Representative)

3/07/2016
Date



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Avenue, Suite#220, Vancouver, WA 98684

April 20, 2016

Aquila Adult Family Home LLC
Aquila Adult Family Home
7601 AQUILLA CT
VANCOUVER, WA 98682

RE: Aquila Adult Family Home License #753001

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on April 14, 2016 for the deficiency or deficiencies cited in the report/s dated February 23, 2016 and found no deficiencies.

The Department staff who did the inspection:
Sarah Bjork, Licensor

If you have any questions please, contact me at (360) 397-9549.

Sincerely,

A handwritten signature in cursive script, appearing to read "Karyl Ramsey for".

Karyl Ramsey, Field Manager
Region 3, Unit E
Residential Care Services