



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 45819, Olympia, WA 98504

October 22, 2019

CERTIFIED MAIL

7018 0680 0000 3183 8496

Dodd's Adult Family Care LLC
Dodd's Adult Family Care LLC
814 Nicholas Ln SE
Lacey, WA 98513

RE: Dodd's Adult Family Care LLC License #753842

Dear Provider:

The Department completed a complaint investigation of your Adult Family Home on October 18, 2019 and found that your home does not meet the adult family home licensing requirements below.

The Department staff who did the investigation and provided consultation:
Jennifer LeMaster, NCI Community Complaint Investigator

Consultation:

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;

On 09/29/19, Staff A (caregiver) noted that four doses of a medication for Resident #1 were missing. Adult family home (AFH) staff notified the department as well as Resident #1's prescribing physician and case manager of the missing medication. Interview showed that Resident #1 chose to wait until their next doctor appointment on 10/03/19 for a refill of the missing medication. Staff B (Provider) installed a second lock on the AFH's medication closet and re-trained staff on medication administration, including storing medications securely and keeping the medicine closet keys secured at all times.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:

- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:

- Inspect the home to determine if you have corrected all deficiencies.

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You May:

- Ask for an informal dispute resolution meeting, according to the attached "Informal Dispute Resolution" instructions; and
- Ask questions and provide written information to help clarify or dispute the deficiencies.

If You Have Any Questions:

- Please contact me at (360) 664-8421.

Sincerely,



Chris Cornell, Field Manager
Region 3, Unit D
Residential Care Services



**Residential Care Services
Investigation Summary Report**

Provider/Facility: Dodd's Adult Family Care LLC (1140723) **Intake ID(s):** 3671817
License/Cert. #: AF753842
Investigator: LeMaster, Jennifer **Region/Unit:** RCS Region 3/Unit D **Investigation Date(s):** 10/09/2019 through 10/18/2019
Complainant Contact Date(s):

Allegations:

Quality of Care/Treatment - An adult family home (AFH) staff member reported that one of Named Resident's medications was missing.

Investigation Methods:

Sample: Named Resident, sample resident

Observations: Named Resident, sample resident, three other residents, care and services, medication administration, medication storage, staff interaction with residents, environment and safety measures

Interviews: Named Resident, sample resident, three other residents, AFH staff, others not associated with the AFH

Record Reviews: Assessment, care plan, and medication administration record for sample resident; incident log; assessment, care plan, medication administration records, physician records, and medication consent for Named Resident



**Residential Care Services
Investigation Summary Report**

Allegation Summary:

Quality of Care/Treatment - Interviews and record review showed that Named Resident missed four days of medication after a caregiver discovered it was missing. Interview showed that Named Resident chose to wait until their next doctor appointment for a refill of the missing medication. AFH staff notified the department and Named Resident's prescribing physician and case manager of the missing medication. The AFH failed to ensure all prescribed resident medications were kept in locked storage. Failed practice was identified.

Unalleged Violation(s): **Yes** **No**

None

Conclusion / Action: **Failed Provider Practice Identified / Citation(s) Written** **Failed Provider Practice Not Identified / No Citation Written**

Quality of Care/Treatment - The AFH failed to ensure all prescribed resident medications were kept in locked storage. See consultation dated 10/18/19.