STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

Mariam's Compassionate Care LLC

Mariam's Compassionate Care LLC
2609 115th Ave NE
Lake Stevens, WA 98258

RE: Mariam's Compassionate Care LLC License # 754338

Dear Provider:

This letter addresses Compliance Determination(s) 64073 (Completion Date 08/12/2025) and 62941 (Completion Date 07/29/2025).

The Department completed a follow-up inspection of your Adult Family Home on 08/12/2025 and found that you have corrected the violations listed in the Complaint report dated 07/29/2025. Your home is back in compliance as of 08/04/2025 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10455-2, WAC 388-76-10485-1

The Department staff who did the on-site verification:
Kimberly Rush, Long Term Care Surveyor

If you have any questions, please contact me at (206)348-9350.

Sincerely,

Nicholette Flynn, AFH Field Manager
Region 2, Unit B
Residential Care Services

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You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 07/22/2025 of:

Mariam's Compassionate Care LLC
2609 115th Ave NE
Lake Stevens, WA 98258

This document references the following complaint number(s): 186560

The following sample was selected for review during the unannounced on-site visit: 3 of 3 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Kimberly Rush, Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223

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As a result of the on-site visit(s), 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 388-76-10455 Medication Administration. For residents assessed with requiring the administration of medications, the adult family home must ensure medication administration is:

(2) By nurse delegation per WAC 246-840-910 through 246-840-970 ; unless

This requirement was not met as evidenced by:

Based on observation, record review, and interview, the Adult Family Home (AFH) failed to ensure medications were administered by staff trained in nurse delegation for 1 of 3 residents (Resident 1). This failure placed Resident 1 at risk for medication errors and medical complications.

Findings included...

WAC 388-76-10000-defines nurse delegation as a registered nurse that transfers the performance of selected nursing tasks to competent nursing assistants, home care aides, or qualified long-term care workers in selected situations. The registered nurse delegating the task retains the responsibility and accountability for the nursing care of the resident.

Record review showed the AFH admitted Resident 1 on [redacted]/2023 with multiple diagnoses that included [redacted] and [redacted]. Resident 1's assessment, dated 02/10/2025, showed Resident 1 required caregivers trained in nurse delegation for medication administration. The assessment showed Resident 1 forgets to take

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medications, unaware of dosages, poor coordination, and cannot open containers.

Observation on 07/22/2025 at 4:12 PM, showed Resident 1 sitting on the couch with an albuterol inhaler (a medication that relaxes and opens air passages to the lungs to make breathing easier) that was inserted into an aerospace chamber (a device that controls the delivery of medication) on their lap. Observed Resident 1 struggling with the aerospace chamber and inhaler. Resident 1 took a breath in, placed the aerospace chamber mouthpiece into their mouth, and pushed down on the albuterol inhaler. Moments later Resident 1 stated out loud that the albuterol didn't work. Staff B (Caregiver) walked from the kitchen to the living room where Resident 1 was sitting on the couch. Staff B ensured the albuterol inhaler was secured in the aerospace chamber and pushed down on the inhaler ensuring that the medication flowed. Staff B handed the albuterol inhaler with the aerospace chamber back to Resident 1 and walked away toward the kitchen. Staff B did not speak to Resident 1 at this time.

Observation on 07/22/2025 at 4:29 PM, Resident 1 was observed trying to bring the aerospace chamber with albuterol inhaler up toward their mouth. Resident 1 stated out loud that they felt like they didn't get any of the medication. Staff B walked back over from the kitchen to Resident 1 on the couch and stated that they did not need to use their albuterol inhaler so much.

Interview on 07/22/2025 at 2:55 PM, Resident 1 stated that the caregivers did not help them use their albuterol inhaler.

Interview on 07/22/2025 at 4:37 PM, Staff B stated that Resident 1 does not use the albuterol inhaler because Resident 1 used one hand and could not take the cap off of the aerospace chamber. Staff B stated that Resident 1 rarely used the albuterol inhaler.

Phone interview on 07/22/2025 at 5:02 PM, Staff A (Entity Representative) stated that caregivers gave Resident 1 all their medications.

Phone interview on 07/23/2025 at 11:19 AM, Collateral Contact 1 (CC1) stated that Resident 1 was not able to push the albuterol inhaler down due to muscle weakness. CC1 stated that Resident 1 told CC1 that they could not remember all the steps on how to use the albuterol inhaler and were worried that the caregivers would not be able to help them. CC1 stated that they asked the caregivers if they knew how to use the albuterol inhaler and the caregivers stated that they did not know. CC1 stated that they did a quick demonstration and showed the caregivers where they could find the instructions on how to use the albuterol inhaler.

Phone interview on 07/29/2025 at 1:14 PM, Staff A stated that they did not contact Resident 1's nurse delegator regarding their albuterol inhaler order because Resident 1 could take the albuterol inhaler themself if the caregivers handed it to them.

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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, Mariam's Compassionate Care LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Provider (or Representative) Date

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, record review, and interview, the Adult Family Home (AFH) failed to ensure all medications were secured in locked storage. This failure placed 1 of 3 residents (Resident 1) at risk of harm and medications errors.

Findings included…

WAC 388-76-10000-defines nurse delegation as a registered nurse that transfers the performance of selected nursing tasks to competent nursing assistants, home care aides, or qualified long-term care workers in selected situations. The registered nurse delegating the task retains the responsibility and accountability for the nursing care of the resident.

Observation of Resident 1's unlocked bedroom on, 07/22/2025 at 2:55 PM, showed Resident 1 laying in bed. Observation showed an overbed table with an unsecured albuterol inhaler (a medication that relaxes and opens airway passages to the lungs to make breathing easier) inserted into an aerospace chamber (a device that controls the delivery of medication).

Interview on 07/22/2025 at 2:55 PM, Resident 1 stated that the caregivers did not help them use their albuterol inhaler.

Record review showed the AFH admitted Resident 1 on [redacted]/2023 with multiple diagnoses that included [redacted]

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[redacted], and [redacted] Resident 1's assessment, dated 02/10/2025, showed Resident 1 required caregivers trained in nurse delegation for medication administration. The assessment showed Resident 1 forgets to take medications, unaware of dosages, poor coordination, and cannot open containers.

Interview on 07/22/2025 at 4:37 PM, Staff B (Caregiver) stated that Resident 1 requested that their albuterol inhaler be left unsecured in their bedroom. At 4:45 PM, Staff B stated that Resident 1 does not use the albuterol inhaler in their bedroom because Resident 1 used one hand and could not take the cap off of the aerospace chamber. Staff B stated that Resident 1 rarely used the albuterol inhaler. At 4:52 PM, Staff B stated that they did not know that Resident 1's albuterol needed to be secured in locked storage.

Interview on 07/22/2025 at 5:02 PM, Staff A (Entity Representative) stated that they were unaware that Resident 1's albuterol inhaler was left unsecured on their overbed table.

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, Mariam's Compassionate Care LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

_____ _____
Provider (or Representative) Date

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