STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, WA 98504-5600

August 9, 2019
Facsimile and Certified Mail

Robert Efford, Administrator
Aacres WA LLC (Spokane County #3)
P.O. Box 39660
Tacoma, WA 98496-0660

Provider Name: Aacres WA LLC (Spokane County #3)
Certification Number 2011-185

Subject: Notice of Provisional Certification and Continued Stop Placement

Dear Mr. Efford:

This is to notify you that Aacres WA LLC (Spokane County #3) ("Provider") is provisionally certified as a Certified Community Residential Services and Supports ("CCRSS") agency, ***effective immediately, August 9, 2019***. The provisional certification period is for 90 days from the effective date indicated above. This provisional certification action is separate from any other action(s), including other findings or certification actions taken by the Department of Social and Health Services (DSHS), the Department of Health, law enforcement, or any other governmental agency.

This letter also constitutes formal notice of a ***continued*** Stop Placement order, initially issued and effective on July 10, 2019, prohibiting all referrals to your Certified Community Residential Services and Support Program by the State of Washington, DSHS, pursuant to the Revised Code of Washington (RCW) 71A.12.300, Washington Administrative Code (WAC) 388-101-4175 and WAC 388-101-4205.

DSHS/Residential Care Services takes these actions based on serious non-compliance with the law and regulations, including Chapter 388-101 and 388-101D WAC. The non-compliance was identified during complaint investigations and a certification evaluation conducted of Aacres WA LLC (Spokane County #3) since initial certification on June 7, 2018.

WAC 388-101-3020 Compliance. Review of the provider's record found that Aacres WA LLC (Spokane County #3) demonstrated serious and recurrent non-compliance with Chapter 388-101 and 388-101D WAC to include but not limited to, as follows:

- ***Statement of Deficiencies, July 31, 2019:***
  -The provider failed to ensure a client received medication as prescribed, received required assistance from staff with preparation for a scheduled colonoscopy, and received immediate medical attention after staff identified

concern of household cleaner ingestion by the client. This resulted in the client ingesting household cleaning vinegar instead of the physician's ordered medication and the client not obtaining immediate medical evaluation which culminated in the client's death.
-The provider failed to provide all relevant information to department investigators during a complaint investigation related to a client's death resulting in pertinent information related to alleged neglect of a vulnerable adult being withheld and not voluntarily provided to department investigators. This interfered with the department's ability to perform regulatory duties as required by law.
-The provider failed to ensure eighteen staff with knowledge of alleged neglect of a client understood and implemented mandated reporting requirements and made reports to the department's centralized toll free complaint telephone number or fax (Complaint Resolution Unit/CRU) immediately. This inaction precluded the department from having immediate knowledge of alleged neglect of a vulnerable adult and delayed the department's investigation of alleged neglect of a client.
-The provider failed to develop clear policies and procedures for supporting clients with medications consistent with regulatory requirements and defining the difference between assistance and administration of medications resulting in conflicting directions regarding medication assistance versus medication administration.
-The provider failed to ensure a Registered Nurse Delegator employed by the provider understood and followed regulatory requirements of WAC 246-840 when they utilized nurse delegation forms for three clients who did not require nurse delegation for oral medications and used contradictory language on nurse delegation documents for a client delegated for oral and topical medications. This resulted in documentation of instructions and actions staff were expected to follow being confusing and unclear.
-The provider failed to provide required medication assistance to a client in a safe manner by four staff which resulted in actual harm to the client when the four staff failed to document prescribed medications for a colonoscopy procedure on the Medication Administration Record, provided colonoscopy medications relying on memory and not specific to the client's instructional plan. A staff did not provide physician ordered medications as prescribed, and two non-medical staff held medications by taking verbal orders over the phone.

- ***Statement of Deficiencies, May 29, 2019 ($6,000 Civil Fines Imposed):***
  - The provider failed to ensure three clients were free from isolation and mental abuse by a staff after multiple witnessed incidents by at least four other staff and knowledge of one supervisor which resulted in ongoing abuse of the three clients.

- The provider failed to ensure staff reported allegations of abuse of three clients immediately to the department's centralized toll-free complaint telephone number or fax number (Complaint Resolution Unit/CRU) as mandatorily required which resulted in a failure to protect the clients and ongoing abuse of the three clients.
- The provider failed to ensure staff implemented the provider's written policies and procedures for immediately reporting incidents involving three clients to the department, to the appropriate persons within the agency, reporting to the alleged victims' legal representative, and taking action to protect the clients from further abuse.

- ***Statement of Deficiencies, February 7, 2019:***
  - The provider failed to ensure Individual Instruction and Support Plans (IISPs) for three clients were reviewed and revised, at least semi-annually, and sent to the case manager for review which resulted in staff not having the most updated instructions on the clients' care needs.

- ***Statement of Deficiencies, December 14, 2018:***
  - The provider failed to ensure long-term care worker training requirements were met for a staff as required per WAC 388-829-0015 which resulted in staff not completing seventy-five hours of required training within the period allowed.
  - The provider failed to allow a client the right to refuse a restriction in place for a housemate which resulted in the client not having access to their property without consent of the client.
  - The provider failed to ensure a client had consent for nurse delegation components in place as required which resulted in the provider not having documentation confirming nurse delegation consent was agreed upon by the client's legal guardian, no documentation of delegated staff, staff not having specific instructions on how to administer delegated tasks to the client, and no 90 day visit paperwork demonstrating the nurse delegator has reviewed the client's current needs.
  - The provider failed to ensure a client's most recent Person Centered Service Plan was used in the client's Individual Instruction and Support Plan which resulted in the client not having the most updated information in their IISP.

- ***Statement of Deficiencies, October 18, 2018:***
  - The provider failed to have a system in place to ensure a client received their medication as prescribed which resulted in the client not taking medication prescribed to treat symptoms associated with mental health conditions for approximately six days.

- The provider failed to contact a client's physician when the client did not receive prescribed psychotropic medication for approximately six days which resulted in the client's physician being unaware of the client's medical situation.

These serious deficiencies have jeopardized clients' health, safety and welfare and they support the issuance of a 90 day provisional certification.

Stop Placement:

The stop placement order prohibiting all admissions to your Certified Community Residential Services and Support Program was **effective immediately** upon facsimile delivery to you on ***July 10, 2019,*** and will continue based on continued non-compliance with Chapter 388-101 and 388-101D WAC. The effective date of the stop placement will not be postponed pending an administrative hearing or informal dispute resolution review.

During the Stop Placement, you may not admit ***any*** referrals (new, pending, and previously accepted) to your Certified Community Residential Services and Support Program. You may not allow clients who are absent from the home due to receiving inpatient services at treatment facilities such as hospitals and nursing homes to return without prior Department approval. This restriction does not extend to clients who are absent from the home only because they are receiving outpatient care. You may request approval for a client to return to the home by contacting Nicole Vreeland, Field Manager, at (360) 725-3218 or Nicole.Vreeland@dshs.wa.gov.

Because it may not be possible to reach the Field Manager on a weekend or holiday, any pre-approval requests should be made as soon as possible during the business week. Such exceptions are made at the sole discretion of the Department on a case-by-case basis. The Department may impose sanctions or take other legal action if you fail to comply with the stop placement order prohibiting referrals.

The stop placement continues to be currently in effect as of August 9, 2019 and will remain in effect until lifted with formal notification from the department. Failure to comply with conditions may lead to further enforcement action and remedies.

Informal Dispute Resolution

If you disagree with the department's find of a violation, or the certification action, you may request an informal dispute resolution pursuant to WAC 388-101-4240. To do so, you must make a written request to the department for an informal dispute resolution meeting within ten working days of receipt of this written notice of the findings and certification action.

Administrative Review

You may request an administrative review of a certification action within twenty-eight days of receipt of this written notice of certification action, pursuant to WAC 388-101-4250. You must make the request in writing and:

- Sign the request;
- Identify the challenged decision and the date it was made;
- State specifically the issues and regulations involved and the grounds for the disagreement and;
- Include with the request copies of any supporting documentation to your position.

To request an Administrative Review, please send your written request to:

Candace Goehring, Director, Residential Care Services
Aging and Long Term Support Administration
P.O. Box 45600
Olympia, WA 98504-5600

Appeal Rights

You may also request an administrative hearing to contest the certification action, pursuant to WAC 388-101-4260, Chapter 71A.12 Revised Code of Washington (RCW) and according to the provisions of Chapter 34.05 RCW and Chapter 388-02 (Washington Administration Code). You must file a hearing request with the Office of Administrative Hearings at the mailing address below. You must make the hearing request within twenty-eight days of receipt of this written notice. Please address any hearing request to:

Office of Administrative Hearings
P.O. Box 42489
Olympia, WA 98504-2489

Please note this provisional certification is effective immediately on August 9, 2019 and will continue pending any Informal Dispute Resolution, Administrative Review and/or administrative hearing. Please do not hesitate to call me at (360) 725-2401 if you have questions or concerns.

Sincerely,

Candace Goehring, Director
Residential Care Services

cc: Cheryl Strange, DSHS Secretary
Bill Moss, ALTSA Assistant Secretary
Evelyn Perez, DDA Assistant Secretary
Norah West, Assistant Director, Office of Communications
Loida Baniqued, RCS Office Chief
Nicole Vreeland, RCS Field Manager
Michael Bradley, Assistant Attorney General
Brooke Boutwell, Assistant Attorney General
Stacie Siebrecht, Disability Rights of Washington
Betty Schwieterman, DD Ombuds
Lorna Morris, DDA Regional Administrator
RCS Central Files