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

April 4, 2018

Facsimile and Certified Mail Delivery

Kendra Ellis, Administrator
SL Start & Associates, LLC
P.O. Box 39660
Tacoma, WA 98496-0660

Subject: Notice of Decertification

Dear Ms. Ellis:

This is to notify you that the certification for SL Start & Associates, LLC to operate as a Certified Community Residential Services and Supports (CCRSS) provider will end on Tuesday, April 17, 2018. Because you will no longer be certified as a CCRSS provider, your agency may no longer provide these services after April 17, 2018.

You will be decertified based on noncompliance with applicable laws and regulations, including Chapter 388-101 and 388-101D Washington Administrative Code (WAC), and your certification will not be extended or renewed. This enforcement action is separate from any other action(s), including other findings or licensing/certification actions taken by the Department of Social and Health Services (DSHS), the Department of Health, law enforcement, or any other governmental agency.

DSHS/Residential Care Services takes this action based on a history of serious and/or recurrent non-compliance with the law and regulations, including Chapter 388-101 WAC, Chapter 388-101D WAC, and Chapter 74.34 RCW. The non-compliance was identified during a review of SL Start's deficiency history as determined through certification evaluations, complaint investigations, follow-up visits, and provisional certification monitoring visits from March 2016 through March 2018. This cumulative compilation of citations listed below may not include deficiencies that may result from current, outstanding investigations and provisional monitoring visits not yet completed as part of your provisional certification enforcement action.

WAC 388-101-3020 Compliance.
The service provider must be in compliance with:
(1) All the requirements of this chapter. Except that, the licensing requirements for adult family homes and assisted living facilities supercede this chapter if the requirements under respective chapters 388-76 and 388-78A WAC conflict with this chapter;
(2) The law governing this chapter, including chapter 71.A.12 and 71A.22 RWC;
(3) The requirements of chapter 74.34 RCW;
(4) The department's residential services contract. Except that, the requirements of this chapter supersede any conflicting requirements with the contract, or appendices to the contract; and
(5) Other relevant federal, state and local laws, requirement, and ordinances.

Review of the provider's record and history from March 2016 through March 2018 found the provider demonstrated recurrent and serious non-compliance with Chapter 388-101 and 388-

101D WAC and Chapter 74.34 RCW and failure to deliver services to clients, to include but not limited to:

- The Provider failed to ensure clients' rights were protected, promoted, and respected as phone calls were being restricted. (Statement of Deficiencies, April 21, 2016, Spokane)
- The Provider failed to provide adequate staffing to six clients when staff were reassigned from client homes to work at a community auction and dinner. **(Statement of Deficiencies, April 29, 2016, Yakima)**
- The Provider failed to provide medical care to a client due to insufficient staffing, failed to get medical care and sufficient medical care which resulted in the client sustaining an infection to an existing injury and skin breakdown. The Provider also failed to ensure two clients' home environment was free of broken equipment and household items, failed to notify the department and law enforcement after a client was assaulted by staff. **(Statement of Deficiencies, June 3, 2016, King County)**
- The Provider failed to follow their own policy and procedure regarding inventory of controlled substance medication for three clients, resulting in property loss. **(Statement of Deficiencies, June 28, 2016, Spokane)**
- The Provider failed to ensure staff documented medication administration records and narrative notes for three clients. The Provider also failed to make two clients' Individual Instruction and Support Plan available to staff, clients, and the department. **(Statement of Deficiencies, July 19, 2016, King County)**
- The Provider failed to develop and document an Individual Instruction and Support Plan for a client. **(Statement of Deficiencies, July 25, 2016, King County)**
- The Provider failed to ensure two clients' home environment was maintained in a healthy and safe manner and an Individual Instruction and Support Plan was developed for a client. **(Statement of Deficiencies, August 25, 2016, King County)**
- The Provider failed to implement behavior tracking for one client who had challenging behaviors and failed to train staff on a client's Individual Service Plan and Positive Behavior Support Plan which resulted in harm. In addition, the client failed to report the incident to the department. **(Statement of Deficiencies, September 20, 2016, King County)**
- The Provider failed to have a client's Individual Instruction and Support Plan available to staff, the client, and the department. **(Statement of Deficiencies, September 26, 2016, King County)**
- The Provider failed to ensure appropriate documentation was completed on two clients' medication administration records. **(Statement of Deficiencies, September 26, 2016, King County)**
- The Provider failed to follow their own policy and procedure regarding controlled substances for three clients, failed to ensure staff provided assistance with daily blood pressure checks for one client, daily monitoring of a client self-administering medications were completed, a client's Individual Instruction and Support Plan was updated as needed for one client, and two clients received medications as ordered. **(Statement of Deficiencies, October 7, 2016, Spokane)**
- The Provider failed to ensure a character, competency, and suitability reviews were completed for staff and two staff had necessary yearly training as required. The Provider also failed to ensure four clients were not restricted from personal property without benefit or plans developed, failed to have nurse delegation consults and/or specific instructions for four clients, failed to have Individual Financial Plans for five clients were in place with necessary information, three client cash accounts on hand failed to match the ledger, and failed to ensure five clients had psychoactive medication

treatment plans. **(Statement of Deficiencies, November 28, 2016, Multiple Locations)**

- The Provider failed to implement policies and procedure to remove staff from client care after an allegation of alleged abuse. **(Statement of Deficiencies, December 15, 2016, Spokane)**
- The Provider failed to ensure staff documented on medication administration records. **(Statement of Deficiencies, December 12, 2016, December 23, 2016, February 16, 2017, February 28, 2017, King County and Spokane)**
- The Provider failed to ensure staff had a clear understanding of job responsibilities and client needs of clients resulting in injury. **(Statement of Deficiencies January 9, 2017, October 9, 2017, King County and Spokane)**
- The Provider failed to ensure two clients had nurse delegated written instructions **(Statement of Deficiencies, January 31, 2017, Multiple Locations)**
- The Provider failed to ensure a client received seizure medications as prescribed for six consecutive days. **(Statement of Deficiencies, February 28, 2017, King County)**
- The Provider failed to report alleged abuse of clients to the department. **(Statement of Deficiencies April 14, 2017, May 4, 2017, July 5, 2017, October 16, 2017, Multiple Locations)**
- The Provider failed to ensure Long-Term Care Worker requirements were met for two staff. **(Statement of Deficiencies, May 11, 2017, Spokane)**
- The Provider failed to ensure two clients' incident reports were completed timely which resulted in inaccurate documentation. The provider also failed to report a client assault to law enforcement. **(Statement of Deficiencies, June 30, 2017, King County)**
- The Provider failed to ensure long-term care worker requirements were in place for staff, required staff training was completed, clients were not restricted from personal property, nurse delegation required elements in the documentation were in place for three clients, a client refusal plan regarding medical care was in place, ongoing updating of clients' Individual Instruction and Support Plan was completed semi-annually, eight client accounts were reconciled and verified, two clients received necessary reimbursement for mismanaged funds, and three clients received medical services as ordered. **(Statement of Deficiencies July 5, 2017, Multiple Locations)**
- The Provider failed to ensure operable smoke detectors were present in two clients' bedrooms. **(Statement of Deficiencies, September 19, 2017, King County)**
- The Provider failed to ensure one client's legal representative was notified of a fall and subsequent hospital emergency room evaluation. **(Statement of Deficiencies, October 9, 2017, Spokane)**
- The provider failed to immediately report five incidents of a client assaulting or threatening their housemate to the department's complaint number. **(Statement of Deficiencies, November 4, 2017, King County)**
- The provider failed to supervise a client who threatened to leave their residence after acknowledging suicidal ideation, was without supervision for several hours, found in another neighboring state in a hospital subsequently being transported by ambulance and escorted by law enforcement after throwing themselves off their wheelchair onto oncoming traffic. **(Statement of Deficiencies, November 14, 2017, King County)**
- The provider failed to maintain staff training documents, ensure staff training were completed, ensure a client received support for repositioning as prescribed by their healthcare provider, ensure requirements for use of medical devices were in place, ensure a client's guardian provided consent for nurse delegation services, ensure home environments for clients were safe, make support plans available to staff in client homes,

ensure clients and/or their legal representatives signed individual financial plans, ensure accurate running balances of client cash accounts were maintained, ensure ledgers for gift cards were maintained for clients, ensure medications were available, given as prescribed to clients and documented, ensure psychoactive medication treatment plans were reviewed with clients and/or their guardians, maintain client property records accurately, and failed to ensure a door alarm was operable for a client who required this in their behavior support plan. **(Statement of Deficiencies, November 20, 2017, Multiple Locations)**

- The provider failed to ensure seven clients received medications as ordered and prescribed. (Statement of Deficiencies, November 27, 2017, Spokane)
- The provider failed to ensure clients homes were of satisfactory condition, ensure a client received their annual dental exam, ensure requirements for use of a medical device was in place for clients, ensure required elements for nurse delegated tasks were met, ensure water temperatures were at a safe temperature for clients, implement and document progress of clients' individual support plans, ensure staff had access to client individual support plans, maintain accurate running balances of client cash accounts, reconcile and verify client bank accounts, maintain a ledger for debited transactions for clients, ensure client medications were given as prescribed, ensure client medications were administered according to instructions of the nurse delegator, document medication administration for a client, ensure psychoactive medication treatment plans were developed for clients, ensure inventory and client property records were accurately documented, conduct and document a functional assessment before developing a behavior support plan for clients, and failed to implement strategies identified in a client's behavior support plan. **(Statement of Deficiencies, December 1, 2017, Multiple Locations)**
- The provider failed to ensure three clients received medication assistance and management as identified in their care plans. **(Statement of Deficiencies, December 12, 2017, Spokane)**
- The provider failed to ensure training requirements were completed as required for staff, ensure requirements for use of medical devices were in place for clients, ensure the required elements were met for nurse delegation tasks for clients, ensure an individual financial plan addressed all of a client's funds managed by the provider, maintain an accurate running balance of client cash accounts, ensure clients' monthly bank accounts were reconciled and verified, ensure medications were available and given as prescribed to clients, ensure client property records were accurately maintained, failed to document instruction and support activities for clients, and ensure restrictive procedures in a client's behavior plan was followed. **(Statement of Deficiencies, December 14, 2017, Multiple Locations)**
- The provider failed to ensure staff immediately reported two allegations of financial exploitation of two clients to the department. **(Statement of Deficiencies, December 26, 2017, Spokane)**
- The provider failed to protect dignity of a client by restricting a client from their fridge (which was locked in the garage), ensure client support and health needs were appropriately documented and completed, provide client health services as required, meet requirements for use of medical devices for clients, have specific written nurse

delegation instructions for a client, maintain water temperatures at a safe temperature for clients, review and revise clients' instruction and support plans, develop a system that ensured food and household supplies purchased for client homes were shared equitably, administer client medications were given as prescribed and/or administered according to nurse delegator instructions, failed to document medication administered to clients, ensure psychoactive medication treatment plans were developed for a client, obtain current release of information consents from clients and/or their legal guardians, ensure restrictive procedures were followed for a client and failed to include strategies for responding to clients' challenging behaviors. **(Statement of Deficiencies, December 28, 2017, Multiple Locations)**

- The provider failed to meet the requirements of a client's care plans, have adequate staff in the home to administer the necessary supports and meet the needs of the client, implement and train staff on policies and procedures regarding mandated reporting and medication support for clients, and ensure staff documented immediately on clients' medication administration records and narrative notes. **(Statement of Deficiencies, December 26, 2017, Spokane)**
- The provider failed to ensure a client received medications as ordered and prescribed. **(Statement of Deficiencies, January 2, 2018, Spokane)**
- The provider failed to ensure a client had required supervision and had medications available and administered which resulted in the client being unsupported, not having medications as prescribed, self-injurious behavior which culminated in hospitalization. **(Statement of Deficiencies, January 12, 2018, Spokane)**
- The provider failed to ensure a client received medications as prescribed which resulted in the client not receiving medications for approximately one month. **(Statement of Deficiencies, January 24, 2018, Spokane)**
- The provider failed to ensure nurse delegation instructions and consents were in place for four clients, client property records were maintained for two clients, and requirements for medical devices were in place for two clients. **(Statement of Deficiencies, February 22, 2018, Multiple Locations)**
- The provider failed to ensure a client received medications as prescribed to alleviate discomfort symptoms for a health condition which resulted in the client not receiving medications for approximately three days. **(Statement of Deficiencies, March 2, 2018, Spokane)**
- The provider failed to follow their own policy and procedures regarding controlled substances which resulted in the client having their medications stolen. **(Statement of Deficiencies, March 6, 2018, Spokane)**
- The provider failed to ensure nurse delegation instructions and consent was in place for a client, failed to maintain balances of cash accounts for four clients, and failed to maintain property records for three clients. **(Statement of Deficiencies, March 8, 2018, Multiple Locations)**
- The provider failed to ensure clients were not restricted from personal property without the appropriate consents in place, water temperatures were maintained at/lower than 120 degrees for four clients, and a client received medications and had the medications administered as prescribed. **(Statement of Deficiencies, March 22, 2018, Spokane and Grandview/Yakima)**

- The provider failed to ensure a client's dental hygiene was sufficiently attended to which resulted in periodontal disease in a necrotizing state. **(Statement of Deficiencies, March 27, 2018, Spokane)**
- The provider failed to obtain appropriate and timely medical evaluation for client who exhibited symptoms outside of their baseline presentation, in which the client subsequently died. (Statement of Deficiencies, March 29, 2018, Spokane)
- The provider failed to ensure clients had their refrigerator and clothing available to them in their home (it was stored in a garage with no documentation to support this need), failed to have consents in place and/or instructions for nurse delegated tasks, failed to document clients' challenging behaviors in positive behavior support plans, and failed to secure sharps for a client who could not have access to them. **(Statement of Deficiencies, April 2, 2018, Multiple Locations)**

These serious deficiencies have jeopardized clients' health, safety and welfare and support decertification of your agency.

WAC 388-101-4180 Remedies—Consideration for imposing remedies.
(1) The department may select enforcement actions proportional to the seriousness of harm or threat of harm to clients served by service providers.
(2) The department may select a more severe enforcement action for violations that are:
(a) Uncorrected;
(b) Repeated;
(c) Pervasive; or
(d) Present a serious threat to the health, safety, or welfare of clients served by the service provider.

WAC 388-101-4200
Remedies—Specific—Decertification.
The department may decertify a service provider at any time for noncompliance with the requirements of this chapter, the department's residential services contract, the requirements of chapter 74.34 RCW, or other relevant federal, state and local laws, requirements or ordinances.

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 decertification is effective immediately on April 17, 2018 and will continue pending any Informal Dispute Resolution, Administrative Review and/or administrative hearing.

Sincerely,

Loida Baniqued

for Candace Goehring, Director
Residential Care Services

cc: Evelyn Perez, Assistant Secretary DDA
Loida Baniqued, RCS Office Chief
Nicole Vreeland, RCS Field Manager
Saif Hakim, DDA Office Chief
Angela Coats McCarthy, Assistant Attorney General
Stacie Siebrecht, Disability Rights of Washington